# 2020 External Quality Review

## ABSOLUTE TOTAL CARE

Submitted: March 25, 2021

Prepared on behalf of the
South Carolina Department
of Health and Human Services

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# EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This report contains a description of the process and the results of the 2020 External Quality Review (EQR) The Carolinas Center for Medical Excellence (CCME) conducted on behalf of the South Carolina Department of Health and Human Services (SCDHHS). This review determines the level of performance demonstrated by Absolute Total Care (ATC) since the 2019 Annual Review.

The goals of the review are to:

- Determine if ATC is following service delivery as mandated in the MCO contract with SCDHHS and in the federal regulations.
- Evaluate the status of deficiencies identified during the 2019 annual external quality review and any ongoing quality improvements taken to remedy those deficiencies.
- Provide feedback for potential areas of further improvement.
- Validate contracted health care services are being delivered and of good quality.

The process CCME used for the EQR was based on the protocols the Centers for Medicare & Medicaid Services (CMS) developed for Medicaid MCO EQRs. The review included a desk review of documents, a two-day virtual onsite visit, a Telephonic Provider Access Study, compliance review, validation of performance improvement projects, validation of performance measures, and validation of satisfaction surveys.

## Summary and Overall Findings

Federal regulations require MCOs to undergo a review to determine compliance with federal standards set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. Specifically, the requirements related to:

- Availability of Services *(§ 438.206, § 457.1230)*
- Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*
- Coordination and Continuity of Care *(§ 438.208, § 457.1230)*
- Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*
- Provider Selection *(§ 438.214, § 457.1233)*
- Confidentiality *(§ 438.224)*

- Grievance and Appeal Systems *(§ 438.228, § 457.1260)*
- Subcontractual Relationships and Delegation *(§ 438.230, § 457.1233)*
- Practice Guidelines *(§ 438.236, § 457.1233)*
- Health Information Systems *(§ 438.242, § 457.1233)*
- Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*

To access ATC's compliance with the quality, timeliness, and accessibility of services, CCME's review was divided into seven areas. The following is a high-level summary of the review results for those areas.

### *Administration:*

*42 CFR § 438.224, 42 CFR § 438.242, 42 CFR § 438, and 42 CFR § 457*

ATC has in place policies and procedures developed to ensure adherence to the *SCDHHS Contract*, and federal regulations.

A review of the ATC 2020 Organizational Chart indicates that sufficient staff coverage is in place to meet each department needs for contractually designated roles. Lines of communication are clearly defined in ATC's training materials and the 2020 ATC Compliance Plan which requires employees to report to management personnel and/or the Compliance Officer all suspected and confirmed incidents of fraud, waste, abuse, illegal acts, inappropriate disclosures, and/or other incidents that contravene applicable law, regulations, or ATC's and Centene's Business Ethics and Conduct policy.

The documentation and data provided by Absolute Total Care demonstrates the organization has the policies, procedures, and information system capabilities to meet the SCDHHS contract requirements. Notably, ATC has a detailed security plan that establishes a sound security posture for the organization. The organization's security plan contains bolstered policies and procedures that address the tasks necessary to maintain that security posture. Additionally, the organization has disaster recovery and business continuity plans to ensure its data and systems are operational in the event of an outage. Finally, ATC's documentation shows that the organization's claims processing rate exceeds the State's requirement. 98.6% of clean claims are paid within 30 days.

The ATC 2020-2021 Compliance and Ethics Program Description outlines the organization's strategic plan to prevent, detect, deter, and correct incidents and practices that do not comply with the law, establishes ethical standards for employees, and delineates the manner in which ethical conduct will be promoted. The Compliance Committee is Chaired by the Compliance Officer and is comprised of a cross-functional team from within the organization, the Board of Directors, and other senior leadership who have the authority to implement corrective actions.

The ATC Auditing and Monitoring Plan outlines steps taken by the Compliance Department. Audits are conducted specific to contractual assessments annually, as needed, and in conjunction to grievance and appeals activities.

Compliance training is conducted at the time of hiring and annually and in written publications to include information on the Compliance Program, the identification of fraud, waste, and abuse and mechanisms to report same, the Code of Conduct, Business Ethics and Conduct policy, HIPAA privacy, the Federal False Claims Act, and other compliance related policies, procedures, and standards. The Business Ethics and Code of Conduct conveys policies of the Company to conduct business in accordance with the standards and rules of ethical business conduct and to abide by applicable laws. The 2020 HIPAA-PHI Desk-Field Audit Training documents clearly present policies, desk and work area audit procedures, and step-by-step violation outcomes. ATC's responses to potential sanctions range from verbal warnings, privilege revocation, financial penalties, to termination.

### *Provider Services:*

*42 CFR § 10(h), 42 CFR § 438.206 through § 438.208, 42 CFR § 438.214, 42 CFR § 438.236, 42 CFR § 438.414, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1230(c), 42 CFR § 457.1233(a), 42 CFR § 457.1233(c), 42 CFR § 457.1260*

Initial provider credentialing and recredentialing processes and requirements are documented in policies, with South Carolina specific requirements found in attachments as needed. ATC follows appropriate timeframes for processing credentialing applications and conducts recredentialing at least every 36 months. Non-discriminatory credentialing and recredentialing practices are employed. ATC's Credentialing Committee uses a peer-review process to make recommendations regarding credentialing decisions. Committee membership includes network practitioners with specialties of Surgery, Pediatrics, and Psychiatry, and the Plan is considering recruiting additional network providers to serve on the committee. CCME suggested an adult medicine provider, such as a Family Practitioner or Internist, be considered. No issues were identified when reviewing Credentialing Committee minutes.

A review of credentialing and recredentialing files revealed that, overall, the files were in good order. It was noted that in some files, the provider's application indicated laboratory services are performed, yet there was no CLIA certificate or certificate of waiver for the location in the file, and other files had provider applications with no response to the question about conducting laboratory services. There was no evidence that ATC contacted the provider for clarification. Additional information was provided to CCME and reviewed. All files were then determined to include appropriate CLIA documentation.

ATC assesses the adequacy of its provider network at least annually using data from network adequacy reports, Geo Access mapping, member satisfaction survey results, and/or appeals and grievances. However, Geo Access mapping conducted in December 2020 did not provide evidence that access was measured for the following Status 1 Provider types: General Surgery and Rehabilitative Behavioral Health. This issue was also identified in the previous EQR. Primary care provider (PCP) appointment and after-hours access, as well as appointment accessibility for specialty and behavioral health providers, are monitored annually, incorporating data and results from member satisfaction surveys, practitioner office surveys, and member grievances and appeals.

The availability of providers who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs, as required by *42 CFR § 438.206(c)(2)*, is ensured. An annual demographics analysis is conducted to identify cultural, linguistic, and accessibility needs of ATC's membership and oversight of contracted providers to ensure compliance with cultural, linguistic, and disability access requirements. Providers receive ongoing education about cultural competency and are requested to document cultural, linguistic, and disability access capabilities. Cultural Competency training documents are available on ATC's website.

Onsite discussion confirmed ATC does not maintain a print (hard copy) version of the Provider Directory; however, members and other stakeholders may use the online Find a Provider tool or contact Member Services to get a list of providers mailed. Information in the Find a Provider Tool is updated daily. CCME could not locate the required statement that some providers may choose not to perform certain services based on religious or moral beliefs in the online Find a Provider Tool or elsewhere on ATC's website. Health plan staff confirmed the statement was inadvertently removed.

Appropriate processes are in place for initial provider orientation and ongoing provider education. In response to restrictions from the COVID-19 pandemic, ATC has adjusted its initial and ongoing provider education practices to include virtual platforms. In addition to formal provider orientation and ongoing education sessions, the Provider Manual and the ATC website are comprehensive sources of information for both new and established network providers.

Clinical practice guidelines and preventive health guidelines are adopted and distributed to assist practitioners and members in making decisions about appropriate health care. All are adopted from recognized sources, are relevant to the membership population, are reviewed at least every two years, and are updated when there is significant new scientific evidence or when there are changes in national standards.

Network providers are monitored for compliance with medical record documentation standards and patient confidentiality requirements via an annual medical record audit. Practitioners who score below the established benchmark are notified of their score, identified deficiencies, and actions to correct the deficiencies. Follow-up is conducted within 6 months. Providers with continued scores below 80% at the time of follow-up are referred with the Medical Director and Contracting/Network Management leadership for further action.

As part of the annual EQR process for ATC, CCME conducted a Telephonic Provider Access Study focused on PCPs. From a list of current ATC providers, a population of 2,557 unique PCPs was found and a sample of 184 providers was randomly selected for the Access Study. Attempts were made to contact the 184 providers to ask a series of questions regarding member access to the providers. Calls were successfully answered 73% of the time, representing an increase of 2% from the previous year's results. This is the fourth consecutive year an increase was noted.

### *Member Services:*

*42 CFR § 438.206(c), 457.1230(a) 42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*

ATC has policies and procedures that define and describe member rights and responsibilities as well as methods of notifying members of their rights and responsibilities. New members receive a welcome packet that includes instructions for contacting Member Services, selecting a PCP, and initiating services. All members have access to information and resources in the Member Handbook, on the website, and in member newsletters to help them use their benefits.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys continue to be conducted annually by a third-party vendor, SPH Analytics. The 2020 survey response rates continue to fall below the National Committee for Quality Assurance (NCQA) target response rate of 40%.

ATC provides the toll-free telephone number, information, and descriptions for Member Services and the 24-Hour Nurse Advice Line in the Member Handbook and on the website. The plan provides a list of preventive health guidelines on the website and in newsletters and encourages members to obtain recommended preventive services.

Processes for grievance handling and resolution are documented throughout policies, the Member Handbook, the Provider Manual, and on ATC's website. Review of grievance files reflect timely acknowledgement and resolution, and notices provided clear and concise information addressing the member's grievance and any follow-up that occurred.

### *Quality Improvement:*

*42CFR §438.330, 42 CFR §457.1240 (b)*

For the Quality Improvement (QI) section, CCME reviewed the 2020 Medicaid Quality Improvement Program Description, committee structure and minutes, performance measures, performance improvement projects, and the QI program evaluations. ATC provided the Absolute Total Care 2020 Quality Assessment and Performance Improvement Program Description Medicaid and Marketplace for review. ATC's primary goal is to ensure that all members have access to the highest quality health care services that are also responsive to their health needs and able to improve their health outcomes. The 2020 QI Program Description clearly outlines the goals and structure of the program.

The work plan is developed annually and facilitates improvement activities for the year. All requirements for the work plan were met.

The Quality Improvement Committee (QIC) is the decision-making body ultimately responsible for the implementation, coordination, and oversight of the QI Program. The QIC is comprised of ATC senior management staff, clinical staff and network practitioners. A quorum must be present to conduct the meeting. Last year, CCME recommended that ATC recruit additional voting members for this committee due to some members not meeting ATC's attendance requirements. To address this recommendation, ATC decided to remove the attendance requirement while ensuring that each department was represented at each meeting. As noted above, a quorum must be met to conduct the meetings; therefore, ATC felt removing the attendance requirement would not jeopardize having enough voting members present.

ATC profiles the quality of care delivered by high-volume PCPs to improve compliance with practice guidelines and clinical performance indicators. ATC indicated that due to COVID-19 and NCQA guidance to rotate rates if necessary, during the HEDIS 2020 (MY2019) hybrid project, ATC did not have audited rates to send out to providers in the provider report cards, so report cards were not sent in CY 2020.

Annually, ATC evaluates the overall effectiveness of the QI Program and reports this evaluation to the Board of Directors and to the Quality Improvement Committee. The Quality Assessment and Performance Improvement Program Evaluation Medicaid and Marketplace - 2019 addressed all aspects of the QI Program.

### *Performance Measure Validation*

ATC uses a NCQA-certified software organization for calculation of Healthcare Effectiveness Data and Information Set (HEDIS) rates, and the validation found all requirements were met. The comparison from the 2019 rate to the 2020 rate revealed a

strong increase (>10%) in several rates, including Statin Therapy Adherence for Patients with Cardiovascular Disease, Comprehensive Diabetes Care - Blood Pressure Control, Statin Adherence for Patients with Diabetes, Diabetes Monitoring for People with Diabetes and Schizophrenia, Cardiovascular Monitoring for People with Schizophrenia, and Postpartum Care. There were no measures with a substantial decline (>10%). *Table 1* highlights the HEDIS measures with substantial increases or decreases in rate from last year to the current year.

**Table 1: HEDIS Measures with Substantial Changes in Rates**

| MEASURE/DATA ELEMENT | HEDIS 2019 | HEDIS 2020 | Change from 2019 to 2020 |
|---|---|---|---|
| **Substantial Increase in Rate (>10% improvement)** | | | |
| Statin Therapy for Patients With Cardiovascular Disease (spc) | | | |
| *Statin Adherence 80% - 40-75 years (Female)* | 50.66% | 63.97% | 13.31% |
| *Statin Adherence 80% - Total* | 50.76% | 61.58% | 10.82% |
| Comprehensive Diabetes Care (cdc) | | | |
| *Blood Pressure Control (<140/90 mm Hg)* | 44.04% | 55.66% | 11.62% |
| Statin Therapy for Patients With Diabetes (spd) | | | |
| *Statin Adherence 80%* | 45.55% | 60.30% | 14.75% |
| *Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)* | 61.93% | 72.88% | 10.95% |
| *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)** | 47.83% | 75.00% | 27.17% |
| Prenatal and Postpartum Care (ppc) | | | |
| *Postpartum Care* | 67.40% | 78.83% | 11.43% |

## *Quality Withhold Measures*

As required by SCDHHS, there were 16 quality clinical withhold measures reported for 2019. The Behavioral Health measures are considered Bonus Only for MY 2019 (reporting year 2020). As per the Medicaid Playbook and *Policy and Procedure Guide for Managed Care Organizations*, individual measures within quality index are weighted differently. A point value is assigned for each measure based on percentile (<10 percentile = 1 point; 10-24 percentile = 2 points; 25-49 percentile = 3 points; 50-74 percentile = 4 points; 75-90 percentile = 5 points; >90 percentile = 6 points). Points attained for each measure are multiplied by individual measure's weights then summed to obtain quality index score. *Table 2: Quality Withhold Measures* shows the 2019 rate, percentile, point value, and index score. The Women's Health measure rates generated the highest index score, followed by Diabetes, and then Pediatric Preventive Care. The Behavioral Health index score reflected an index score of 2.25.

**Table 2: Quality Withhold Measures**

| Measure | MY 2019 Rate | MY 2019 Percentile | Point Value | Index Score |
|---|---|---|---|---|
| DIABETES | | | | |
| Hemoglobin A1c (HbA1c) Testing | 89.29 | 90 | 6 | 4.9 |
| HbA1c Control (< =9) | 42.34 | 50 | 4 | |
| Eye Exam (Retinal) Performed | 57.91 | 75 | 5 | |
| Medical Attention for Nephropathy | 90.79 | 50 | 4 | |
| WOMEN'S HEALTH | | | | |
| Timeliness of Prenatal Care | 93.67 | 90 | 6 | 5.1 |
| Breast Cancer Screen | 62.64 | 75 | 5 | |
| Cervical Cancer Screen | 65.94 | 75 | 5 | |
| Chlamydia Screen in Women (Total) | 61.47 | 50 | 4 | |
| PEDIATRIC PREVENTIVE CARE | | | | |
| 6+ Well-Child Visits in First 15 months of Life | 72.51 | 75 | 5 | 3.3 |
| Well Child Visits in 3rd, 4th, 5th & 6th Years of Life | 63.75 | 10 | 2 | |
| Adolescent Well-Care Visits | 55.96 | 25 | 3 | |
| Weight Assessment/Adolescents: BMI % Total | 87.59 | 75 | 5 | |
| BEHAVIORAL HEALTH | | | | |
| FUH - Follow-Up After Hospitalization for Mental Illness - 7 Days | 32.33 | 50 | 4 | 2.25 |
| IET - Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Initiation – Total | 39.22 | 25 | 3 | |
| ADD- Follow Up for Children Prescribed ADHD Medication – Initiation | 44.08 | 25 | 3 | |
| AMM - Continuation Phase-Antidepressant Medication Management - 180 Days (6 Months) | 23.13 | <10 | 1 | |
| APM- Metabolic Monitoring for Children & Adolescents on Antipsychotics - Total | 25.08 | 10 | 2 | |
| APP- Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics - Total | 58.71 | 25 | 3 | |

### *Performance Improvement Project Validation*

ATC submitted three projects for validation: Postpartum Care, Provider Satisfaction, and Hospital Readmissions. *Table 3: Performance Improvement Project Validation Scores* provides an overview of the previous year's validation scores with the current scores.

**TABLE 3: Performance Improvement Project Validation Scores**

| Project | 2019 Validation Score | 2020 Validation Score |
|---|---|---|
| Postpartum Care | 98/98=100%<br>High Confidence in Reported Results | 100/100=100%<br>High Confidence in Reported Results |
| Provider Satisfaction | 87/88=99%<br>High Confidence in Reported Results | Not validated due to a delay in conducting the Provider Satisfaction survey |
| Hospital Readmissions | Not validated/Not yet active | 72/72=100%<br>High Confidence in Reported Results |

The PIPs validated received a score within the High Confidence Range and met the validation requirements per *42 CFR §438.330 (d) and §457.1240 (b)*.

Last year, it was noted the rate for the Provider Satisfaction PIP decreased from baseline. ATC indicated the provider satisfaction workgroup met and interventions were discussed. Those included additional staff training, the implementation of the Interpreta application that allows network providers to receive real-time care gap reports, and hosting regional provider meetings. To help improve Provider Satisfaction, CCME recommended ATC continue those interventions. For this EQR, CCME was unable to assess the effectiveness of those interventions because the provider satisfaction survey was delayed and the results were not available for this review. Staff did indicate that preliminary results showed some improvements.

The Postpartum Care and a new Readmissions PIP were validated during this EQR. The Postpartum Care PIP did show an improvement in the rate although it was still below the benchmark rate. Interventions for this PIP include pay for performance initiatives for providers, transportation and outreach education for members, the Interpreta platform for real-time data, and a car seat initiative for members. The Readmissions PIP had baseline data only and therefore improvement was not yet evaluated. There are several interventions underway for this PIP that are using ATC's Post Hospital Outreach Team to assess the member's needs before and after discharge, medication reconciliation with the primary care provider, and referrals to Case Management as needed.

### *Utilization Management:*

*42 CFR § 438.210(a–e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228, 42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260, 42 CFR § 208, 42 CFR § 457.1230 (c),42 CFR § 208, 42 CFR § 457.1230 (c)*

The Utilization Management (UM) Program Description outlines the purpose, goals, objectives, and staff roles for physical health and behavioral health. Policies and procedures provide guidance to staff on handling service authorization requests. Appropriate reviewers conduct service authorization requests using InterQual guidelines, internal clinical guidelines, or other established criteria. Additionally, ATC has established policies defining processes for handling appeals of adverse benefit determinations. Overall, the review of approval, denial, and appeal files provided evidence that appropriate processes are followed.

Pharmacy benefit information is available in various policies and on the website. Policy CC.PHAR.10, Preferred Drug List Addendum, is specific to South Carolina; however, it describes processes for communicating negative PDL changes at the corporate level and at the state level, which are not clearly defined and are confusing. The PDL Updates posted on the website have at least four "effective" dates documented which makes it difficult to determine when the updates are truly effective.

The Care Management (CM) Program Description and policies appropriately document care management processes and services provided. ATC has a person-centered model that encompasses a multi-disciplinary team approach. CM files indicate care gaps are identified and addressed consistently and services are provided for various risk levels.

### *Delegation:*

*42 CFR § 438.230 and 42 CFR § 457.1233(b)*

Policies are in place to define delegation processes and requirements. Pre-delegation assessments are conducted for all potential delegates to determine the entities' ability to meet requirements of delegated functions. Delegation agreements with each delegate are signed and ongoing monitoring is conducted to ensure continued compliance with all requirements. The ongoing monitoring includes annual auditing along with quarterly Joint Operating Committee meetings. Additionally, delegates are required to submit reports of activities on a pre-defined schedule.

Documentation of annual oversight and minutes from quarterly Joint Operating Committee meetings for each delegate were submitted. CCME's review of the documentation confirms appropriate monitoring is conducted. Oversight and monitoring tools included appropriate elements for the functions delegated to each entity. Any

identified deficiencies and applicable corrective actions were noted in the monitoring reports.

### *State Mandated Services:*

*42 CFR § Part 441, Subpart B*

ATC's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program follows the Bright Futures Periodicity Schedule for required screenings and health treatments. ATC monitors provider compliance with EPSDT services and required immunizations through HEDIS requirements and medical record reviews conducted by the Quality Department. The 2019 Medicaid Quality Improvement Program Evaluation identified EPSDT performance measures below established benchmarks.

The plan is required to address deficiencies identified in the previous EQR. However, ATC did not include the following Status 1 Provider types: General Surgery and Rehabilitative Behavioral Health, on the Geo Access mapping report conducted on December 21, 2020.

## *Quality Improvement Plans and Recommendations from Previous EQR*

During the 2019 EQR, eight standards were scored as "Partially Met" and no standards scored as "Not Met." Following the 2019 EQR, ATC submitted a Quality Improvement Plan to address the identified deficiencies. CCME reviewed and accepted the Quality Improvement Plan on May 5, 2020. The following is a high-level summary of those deficiencies:

- The 2019 Compliance Plan did not reflect that new provider orientation would include training on the identification and reporting of FWA.
- The query of the SCDHHS Terminated for Cause List and the SCDHHS Excluded Provider List was not conducted for some of the credentialing and recredentialing files.
- Copies of the Clinical Laboratory Improvement Amendment (CLIA) certificates were not included in some of the credentialing and recredentialing files even though the provider indicated on the application that laboratory services were provided at locations where they currently practice.
- Issues identified with the organizational credentialing files included:
    - One file did not contain a copy of the facility's CMS certification. The CMS certification provided was for a different facility.
    - A copy of the facility's license was not provided for 2 facility files.
    - The SCDHHS Excluded Provider List query for one facility was more than a year old.
    - The date of verification for one facility's NPI number was missing.

  - The ownership disclosure form for one facility was not dated
- The GEO Access Reports did not include the geographic access for Rehabilitative Behavioral Health providers and Audiology Therapy providers.
- The Member Handbook and Provider Manual contained errors regarding a clinically urgent grievance process.
- The processes for posting changes to the preferred drug list and notifying impacted members and providers of the changes were incorrect in Policy CC.PHAR.10, Preferred Drug List.

During the current EQR, CCME assessed the degree to which the health plan implemented the actions to address these deficiencies and found that one item on the Quality Improvement Plan was not implemented, resulting in an uncorrected deficiency. This was related to failure to include all Status 1 providers in specifications for Geo Access mapping.

*Table 4: Scoring Overview*, provides an overview of the scoring of the current annual review as compared to the findings of the 2019 review. 212 of 214 standards received a score of "Met." One standard was scored as "Partially Met" and one standard received a "Not Met" score.

**Table 4: Scoring Overview**

| | Met | Partially Met | Not Met | Not Evaluated | Not Applicable | Total Standards | *Percentage Met Scores |
|---|---|---|---|---|---|---|---|
| Administration | | | | | | | |
| 2019 | 40 | 0 | 0 | 0 | 0 | 40 | 100% |
| 2020 | 40 | 0 | 0 | 0 | 0 | 0 | 100% |
| Provider Services | | | | | | | |
| 2019 | 72 | 6 | 0 | 0 | 0 | 78 | 92% |
| 2020 | 75 | 1 | 0 | 0 | 0 | 76 | 99% |
| Member Services | | | | | | | |
| 2019 | 32 | 1 | 0 | 0 | 0 | 33 | 97% |
| 2020 | 33 | 0 | 0 | 0 | 0 | 33 | 100% |
| Quality Improvement | | | | | | | |
| 2019 | 14 | 0 | 0 | 0 | 0 | 14 | 100% |
| 2020 | 14 | 0 | 0 | 0 | 0 | 14 | 100% |
| Utilization | | | | | | | |
| 2019 | 44 | 1 | 0 | 0 | 0 | 45 | 98% |

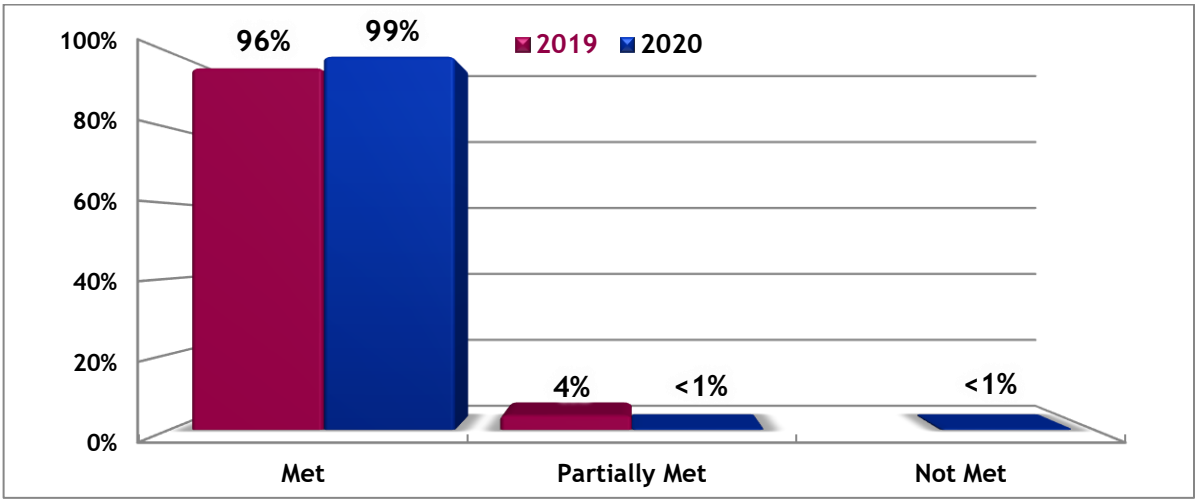
| | Met | Partially Met | Not Met | Not Evaluated | Not Applicable | Total Standards | *Percentage Met Scores |
|---|---|---|---|---|---|---|---|
| 2020 | 45 | 0 | 0 | 0 | 0 | 45 | 100% |
| Delegation | | | | | | | |
| 2019 | 2 | 0 | 0 | 0 | 0 | 2 | 100% |
| 2020 | 2 | 0 | 0 | 0 | 0 | 2 | 100% |
| State Mandated Services | | | | | | | |
| 2019 | 4 | 0 | 0 | 0 | 0 | 4 | 100% |
| 2020 | 3 | 0 | 1 | 0 | 0 | 4 | 75% |
| **Totals** | | | | | | | |
| **2019** | **208** | **8** | **0** | **0** | **0** | **216** | **96%** |
| **2020** | **212** | **1** | **1** | **0** | **0** | **214** | **99.07%** |

**Percentage is calculated as: (Total Number of Met Standards / Total Number of Evaluated Standards) × 100*

## *Conclusions*

Overall, ATC met the requirements set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. The 2020 Annual EQR shows that ATC has achieved a "Met" score for 99.07% of the standards reviewed. As the following chart indicates, 0.47% of the standards were scored as "Partially Met" and 0.47% scored as "Not Met." The chart that follows provides a comparison of the current review results to the 2019 review results.

**Figure 1: Annual EQR Comparative Results**




*Scores were rounded to the nearest whole number*

The following is a summary of key findings and recommendations or opportunities for improvements. Specific details of strengths, weaknesses, and recommendations can be found in the sections that follow.

- ISCA policies and procedures adhere to best practices and are reviewed and updated regularly.
- Disaster recovery (DR) tests include actual system recovery, which is preferred when compared to DR tests that use desktop exercises that only step through recovery plans.
- Credentialing and recredentialing processes are thorough with files containing all required elements.
- The Telephonic Provider Access Study success rate increased 2% from the 2019 study results. This is the fourth consecutive year an increase was noted.
- The 2020 medical record audit of 69 practitioners resulted in all practitioners receiving a total passing score of ≥ 80% with 11 providers scoring 100%.
- The Credentialing Committee membership does not include a network adult medicine provider, such as a Family Practitioner or Internal Medicine provider.
- ATC provides all core benefits according to *SCDHHS Contract*.
- Medical, behavioral health, and pharmacy UM Reviewers scored above the benchmark goal of 90% on the annual inter-rater reliability tests.
- Determination letters are written in language that is easily understood by a layperson and medical terminology is explained, when used.
- All PIPs received validation scores in the "High Confidence Range."
- Documentation reflected appropriate delegation oversight and monitoring activities are conducted. Delegation monitoring and oversight tools include appropriate elements for the type of delegation.

### *Recommendations and Opportunities for Improvements*

Areas needing corrections and recommendations include:

- Consider adding an adult medicine provider, such as a Family Practitioner or Internal Medicine provider, to the Credentialing Committee's membership.
- Ensure Geo Access reports measure access to all required Status 1 providers.
- Edit Policy SC.ELIG.17, Enrollment, to indicate when ATC receives member enrollment data from SCDHHS and to reflect that members receive benefit information in writing within 14 days according to *SCDHHS Contract, Section 3.14.3*.

- Continue working with SPH Analytics to increase response rates and identify methods to improve responses. Social media posts, text reminders (if possible), and reminders during call center interactions are encouraged to be continued.
- Policy CC.PHAR.10, Preferred Drug List Addendum, describes processes for communicating negative PDL changes; however, it includes processes both at the corporate level and state level which are not clearly defined and are confusing.
- The PDL Updates posted on the website have several "effective" dates documented which makes it difficult to determine when the updates are truly effective.
- The "Notice of Your Right to a State Fair Hearing," enclosed with the Appeal Upheld letter, instructs the reader to send a copy of the notice of resolution. However, the Appeal Upheld letter template does not have a reference or indication that it is also the notice of resolution and the reader may not understand that it is the same.
- The Case Management Society of America's (CMSA) definition of case management is inconsistently documented on page six of the Case Management Program Description and on page 28 of Policy SC.CM.02, Care Coordination/Care Management Services.

# METHODOLOGY

The process CCME used for the EQR activities was based on protocols CMS developed for the external quality review of a Medicaid MCO/PIHP and focuses on the three federally mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects.

On December 7, 2020, CCME sent notification to ATC that the Annual EQR was being initiated (see *Attachment 1*). This notification included a list of materials required for desk review and an invitation for a teleconference to allow ATC the opportunity to ask questions regarding the EQR process and the requested desk materials.

The review consisted of two segments. The first was a desk review of materials and documents received from ATC on December 21, 2020 and reviewed in CCME's offices (*see Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. Also included in the desk review was a review of credentialing, grievance, utilization, case management, and appeal files.

The second segment was a virtual onsite review conducted on February 24th and 25th. The onsite visit focused on areas not covered in the desk review or needing clarification. See *Attachment 2* for a list of items requested for the onsite visit. Onsite activities included an entrance conference; interviews with ATC's administration and staff; and an exit conference. All interested parties were invited to the entrance and exit conferences.

# FINDINGS

The EQR findings are summarized below and are based on the regulations set forth in *42 CFR Part 438 Subpart D*, the Quality Assessment and Performance Improvement program requirements described in *42 CFR § 438.330,* and the Contract requirements between ATC and SCDHHS. Strengths, weaknesses, and recommendations are identified where applicable. Areas of review were identified as meeting a standard ("Met"), acceptable but needing improvement ("Partially Met"), failing a standard ("Not Met"), "Not Applicable," or "Not Evaluated," and are recorded on the tabular spreadsheet (*Attachment 4*).

## A. Administration

*42 CFR § 438.242, 42 CFR § 457.1233 (d), 42 CFR § 438.224*

The overall approach by ATC for the development of policies and procedures is to ensure adherence to the *SCDHHS Contract* and federal regulations. Onsite discussion revealed

that monitoring and auditing is conducted routinely by the Compliance Department for annual policy review and revisions. Staff are informed of new and revised policies.

Sufficient staff coverage is in place per the ATC 2020 Organizational Chart, which indicates contractually designated departmental needs and roles are met. The ATC 2020 Compliance Plan and Human Resource training materials detail lines of communication that clearly require employees to report to management and/or the Compliance Officer all suspected and confirmed incidents of fraud, waste, abuse, illegal acts, inappropriate disclosures, and/or other incidents that contravene applicable law, regulations, or ATC's and Centene's Business Ethics and Conduct policy.

Information Systems Capabilities Assessment documentation and data provided by ATC demonstrate the organization has policies, procedures, and system capabilities to meet *SCDHHS Contract* requirements. Notably, ATC has a detailed security plan that establishes a sound security posture for the organization. The security plan contains bolstered policies and procedures that address tasks necessary to maintain the security posture. Additionally, ATC has disaster recovery and business continuity plans to ensure its data and systems are operational in the event of an outage. Finally, ATC's documentation shows that the organization's claims processing rate exceeds the State's requirements.

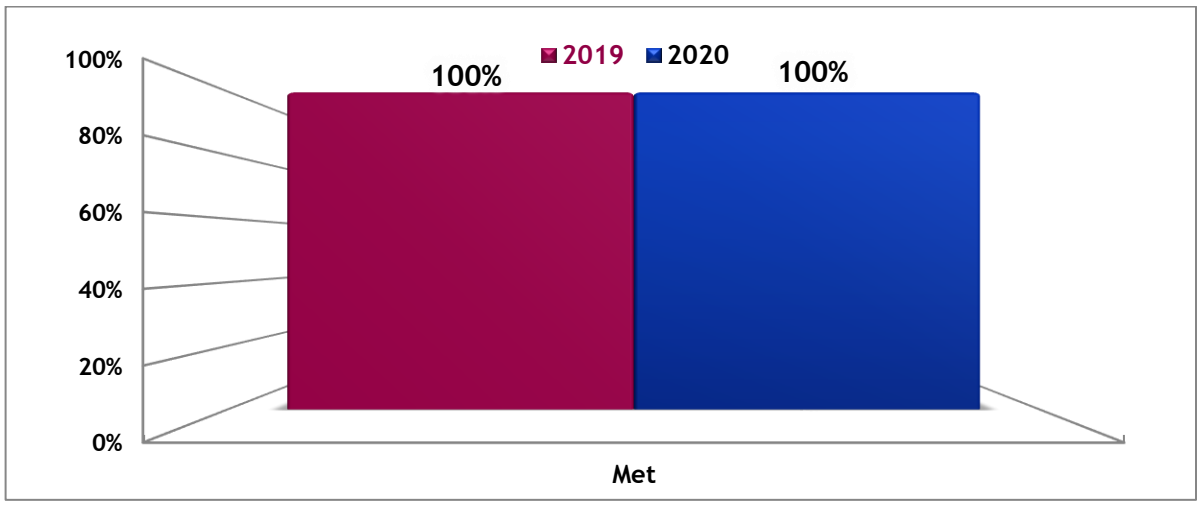
The ATC 2020-2021 Compliance and Ethics Program Description outlines the organization's strategic plan to prevent, detect, deter, and correct incidents and practices that do not comply with the law, establishes ethical standards for employees, and delineates the way ethical conduct will be promoted. The Compliance Committee is chaired by the Compliance Officer and includes a cross-functional team from within the organization, the Board of Directors, and other senior leadership who have the authority to implement corrective actions. The ATC Auditing and Monitoring Plan outlines steps taken by the Compliance Department. Audits are conducted specific to contractual assessments annually, as needed, and in conjunction with grievance and appeals activities.

Compliance training is conducted at the time of employment and annually, and staff are provided with written publications to include information on the Compliance Program; the identification of and reporting mechanisms for fraud, waste, and abuse; the Code of Conduct, Business Ethics and Conduct policy; HIPAA privacy; the Federal False Claims Act; and other compliance-related policies, procedures, and standards. The Business Ethics and Code of Conduct conveys policies of the Company to conduct business in accordance with the standards and rules of ethical business conduct and to abide by applicable laws. The 2020 HIPAA-PHI Desk-Field Audit Training documents present policies, desk and work area audit procedures, and step-by-step violation outcomes.

ATC's responses to potential sanctions range from verbal warnings, privilege revocation, financial penalties, to termination.

All the standards in the Administration section received a "Met" score.

**Figure 2: Administration Findings**




### *Strengths*

- The ISCA policy and procedure documentation adheres to best practices and are reviewed and updated regularly.
- The ATC disaster recovery (DR) capabilities include a physical fail-over location.
- Disaster recovery tests include actual system recovery, which is preferred compared to DR tests that only use desktop exercises that only step through recovery plans.

## B. Provider Services

*42 CFR § 438.10(h), 42 CFR § 438.206 through § 438.208, 42 CFR § 438.214, 42 CFR § 438.236, 42 CFR § 438.414, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1230(c), 42 CFR § 457.1233(a), 42 CFR § 457.1233(c), 42 CFR § 457.1260*

The Provider Services review includes credentialing and recredentialing, network adequacy and provider accessibility, provider education, clinical and preventive practice guidelines, practitioner medical records, and continuity of care.

### *Provider Credentialing and Selection*

Initial provider credentialing and recredentialing processes and requirements are documented in Policy CC.CRED.01, Practitioner Credentialing & Recredentialing, with South Carolina specific requirements found in an attachment. Requirements and processes for organizational providers are addressed in Policy CC.CRED.09, Organizational

Assessment and Reassessment. ATC ensures credentialing applications are processed within 60 calendar days from receipt of a complete application, and recredentialing occurs at least every 36 months. Non-discriminatory credentialing and recredentialing practices are employed. Applicants for initial credentialing and recredentialing determined to have "clean files," as defined in Policy CC.CRED.01, may be approved by the Medical Director. Credentialing and/or recredentialing files that do not meet criteria for clean file review are presented to the Credentialing Committee for review and determination.

ATC's Credentialing Committee uses a peer-review process to make recommendations regarding credentialing decisions. The committee meets monthly, is chaired by the Chief Medical Director, and is overseen by the Quality Improvement Committee (QIC). Committee membership includes network practitioners with specialties of Surgery, Pediatrics, and Psychiatry; however, ATC's Chief Medical Director confirmed the Plan is considering recruiting additional network providers to serve on the committee. CCME suggested they consider adding an adult medicine provider, such as a Family Practitioner or Internist, to the committee's membership. CCME's review of Credentialing Committee minutes confirmed thorough review and discussion of providers under consideration who have adverse items, discussion of ongoing monitoring and interventions, discussion of delegation oversight activity, etc. A quorum was confirmed for each of the meetings reviewed and member attendance was satisfactory.

CCME reviewed a sample of credentialing and recredentialing files for primary care providers (PCPs), specialists, behavioral health practitioners, and organizational providers. Overall, the files were in good order. In some files, the provider's application indicated laboratory services are performed, yet there was no CLIA certificate or certificate of waiver for the location in the file. Other files had provider applications with no response to the question about conducting laboratory services, and there was no evidence that ATC contacted the provider for clarification. For the files in question, additional information was provided. After review of the additional information, all files included appropriate CLIA documentation.

### *Availability of Services*

Processes have been established to monitor how effectively the network meets membership needs by determining the type, number, and geographic distribution of PCPs, specialists, and organizational providers in ATC's network. ATC assesses provider availability against the defined standards at least annually using data from network adequacy reports, Geo Access mapping, member satisfaction survey results, and/or appeals and grievances. Geo Access reports are run semi-annually, and network reporting is provided to SCDHHS twice yearly. However, Geo Access mapping dated December 21, 2020 did not provide evidence that access was measured for the following Status 1

Provider types: General Surgery and Rehabilitative Behavioral Health. Additional Geo Access mapping was submitted reflecting measurement of General Surgery and Rehabilitative Behavioral Health providers but the date of the mapping was 2/26/21, after completion of the onsite. Failure to include all Status 1 providers in Geo Access mapping was an issue previously identified in the 2019 EQR.

Primary care provider appointment and after-hours access, as well as appointment accessibility for specialty and behavioral health providers, are monitored annually. The monitoring incorporates data and results from member satisfaction surveys, practitioner office surveys, and member grievances and appeals.

A demographics analysis is conducted annually to identify members' cultural, linguistic, and accessibility needs. Regular quality assurance oversight of contracted providers is performed to ensure compliance with cultural, linguistic, and disability access requirements. This is accomplished through review of policies and procedures, site visits, and monitoring member satisfaction survey results, appeals, and grievances. Providers receive ongoing education about cultural competency, and cultural competency training documents are available on ATC's website.

Onsite discussion confirmed ATC does not maintain a print (hard copy) version of the Provider Directory; however, members and other stakeholders may contact Member Services to request a list of providers. The online Find a Provider tool allows providers to be located by name, location, or specialty. General results can be filtered by distance, provider type, gender, disability access, and status for accepting new patients. The online Find a Provider Tool includes all elements required for the Provider Directory, and onsite discussion confirmed the information in the tool is updated daily. The *SCDHHS Contract, Section 3.13.5.7,* and the *Social Security Act, Section 1932(b) (3) (B),* require the provider directory to include a statement that some providers may choose not to perform certain services based on religious or moral beliefs. This statement was not noted in the online Find a Provider Tool or elsewhere on ATC's website. Onsite discussion confirmed this statement was inadvertently removed.

Provider/Network Relations staff conduct initial provider orientation and education within 30 business days of the provider becoming active with ATC. A provider orientation PowerPoint presentation, along with the Provider Manual, is used for initial provider education to cover core topics and provide additional related information. The Provider Manual is a comprehensive source of information for both new and established network providers. ATC's website is also a resource for providers and contains a pre-authorization check tool, information about the Quality Improvement Program, the Provider Manual, forms, provider training documents, information about eligibility verification, appeals, and grievances, and a host of other topics to assist providers in navigating the health plan. Additionally, providers may access the secure Provider Portal on ATC's website.

Ongoing provider education is accomplished in a variety of ways, including face-to-face visits with Provider/Network Relations Representatives, provider training sessions held in regional locations throughout the state, faxes and mailings, newsletters, website updates, etc. In response to restrictions from the COVID-19 pandemic, ATC has adjusted its initial and ongoing provider education practices, and all education sessions are now conducted through virtual platforms.

Clinical practice guidelines and preventive health guidelines are adopted and distributed to assist practitioners and members in making decisions about appropriate health care. All are adopted from recognized sources, are relevant to the membership population, are reviewed at least every two years, and are updated when there is significant new scientific evidence or when there are changes in national standards. Through the Quality Improvement Committee (QIC), board-certified practitioners are involved in guideline review and adoption. Network providers are informed that they may be audited for compliance with use of the guidelines.

Processes for monitoring network providers to ensure they are compliant with medical record documentation and patient confidentiality standards are found in Policy SC.QI.13, Medical Record Review. An annual medical record audit of a statistically valid sample of selected PCPs is conducted; high volume specialists may also be included. Practitioners who score below the benchmark score of 80% are given written notice of the score, identified deficiencies, and actions required to correct the deficiencies. Follow-up is conducted within 6 months. Providers with continued scores below 80% at the time of follow-up are referred with the Medical Director and Contracting/Network Management leadership for further action. The Medicaid Medical Record Review 2020 Annual Audit Report reveals ATC audited 69 practitioners. All practitioners received a total passing score of ≥ 80%; the overall score was 95% and 11 practitioners scored 100%.

### *Provider Access and Availability Study*

*42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*

As part of the annual EQR process for ATC, CCME conducted a provider access study focused on primary care providers. A list of current providers was given to CCME by ATC, from which a population of 2,557 unique PCPs was found. A sample of 184 providers was randomly selected from this population for the Access Study. Attempts were made to contact the 184 providers to ask a series of questions regarding member access to the providers.

Calls were successfully answered 73% of the time (109 of 149) when omitting calls answered by personal or general voicemail messaging services. When compared to last year's results of 71%, this year's study had an increase in successful calls at 73%

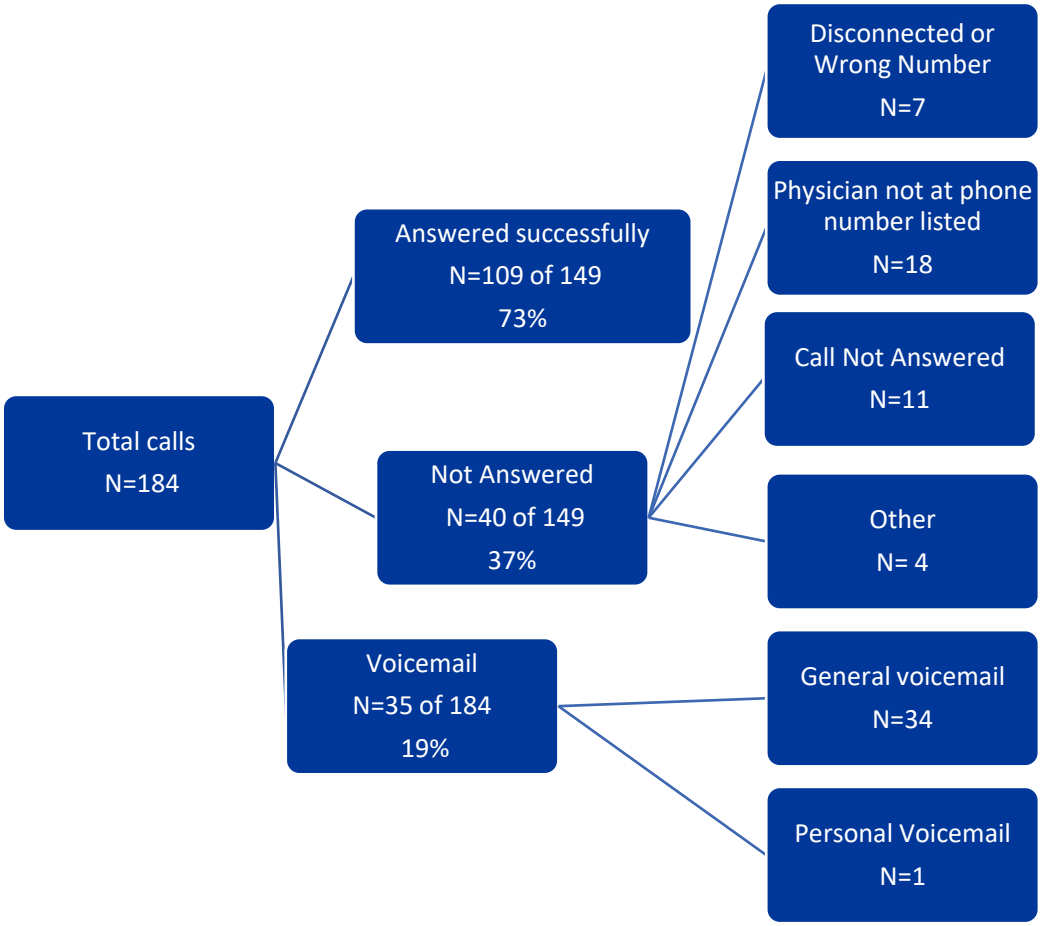
(p=.6454), as shown in *Table 5: Telephonic Access Study Answer Rate Comparison*. This increase of 2% was not statistically significant.

**Table 5: Telephonic Access Study Answer Rate Comparison**

| Review Year | Sample Size | Answer Rate | p-value |
|---|---|---|---|
| 2019 Review | 289 | 71% | 0.654 |
| 2020 Review | 184 | 73% | |

*Figure 3: Telephonic Provider Access Study Results* provides an overview of the results of the Telephonic Provider Access Study.

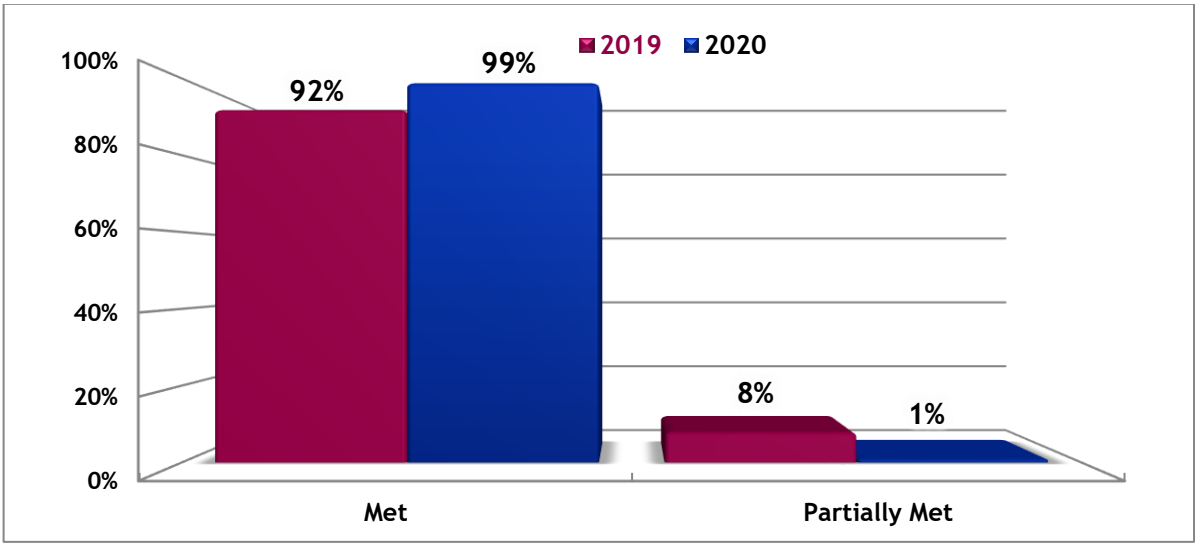
**Figure 3: Telephonic Provider Access Study Results**



For the 40 calls not answered successfully, 11 (28%) were because there was no answer, seven (18%) were due to a wrong or disconnected phone number, and 18 (45%) were because the caller was informed that the physician was no longer at the location. For the question "Do you accept Absolute Total Care?" 82 of 109 (75%) confirmed they accept ATC. Of the 82 providers that responded to the question regarding accepting new Medicaid patients, 56 of 91 (68%) confirmed they are accepting new Medicaid patients; 33 of those 56 (59%) indicated they have prescreening requirements. Of the 33 providers with prescreening requirements, 23 (70%) required an application and a medical record review, and nine (18%) required only an application. One provider (3%) required an insurance card and ID.

*Figure 4: Provider Services Findings* shows 99% of the standards in Provider Services received a "Met" score. *Table 6: Provider Services Comparative Data* highlights changes in scores from 2019 to 2020.

**Figure 4: Provider Services Findings**




*Percentages may not total 100% due to rounding*

**Table 6: Provider Services Comparative Data**

| SECTION | STANDARD | 2019 REVIEW | 2020 REVIEW |
|---|---|---|---|
| Credentialing and Recredentialing | For initial credentialing, verification of information on the applicant, including:<br>Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List; | Partially Met | Met |

| SECTION | STANDARD | 2019 REVIEW | 2020 REVIEW |
|---|---|---|---|
| Credentialing and Recredentialing | Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures; | Partially Met | Met |
| | For recredentialing, verification of information on the applicant, including:<br>Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List; | Partially Met | Met |
| | Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures; | Partially Met | Met |
| | Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities. | Partially Met | Met |
| Adequacy of the Provider Network | Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty. | Partially Met | Met |
| | The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually. | Met | Partially Met |

*The standards reflected in the table are only the standards that showed a change in score from 2019 to 2020.*

### *Strengths*

- Credentialing and recredentialing files contain all required elements.
- The Telephonic Provider Access Study success rate increased 2% from the 2019 study results. This is the fourth consecutive year an increase was noted.
- The 2020 medical record audit of 69 practitioners resulted in all practitioners receiving a total passing score of ≥ 80% with 11 providers scoring 100%.

### *Weaknesses*

- The Credentialing Committee membership does not include a network adult medicine provider, such as a Family Practitioner or Internal Medicine provider.

- Geo Access reports submitted with ATC's desk materials did not provide evidence that access was measured for the following Status 1 Provider types: General Surgery and Rehabilitative Behavioral Health. Additional documentation (Geo Access mapping) was provided showing measurement of General Surgery and Rehabilitative Behavioral Health providers, but the date of the mapping was February 26, 2021, after completion of the onsite.

- The *SCDHHS Contract, Section 3.13.5.7,* and the *Social Security Act, Section 1932(b) (3) (B),* require the provider directory to include a statement that some providers may choose not to perform certain services based on religious or moral beliefs. ATC does not maintain a print version of the Provider Directory, and the required statement was not noted in the online Find a Provider Tool or elsewhere on ATC's website. Onsite discussion confirmed this statement was inadvertently removed.

- The Provider Manual, page seven, does not clearly define all appointment access standards for specialists.

### *Quality Improvement Plans*

- Ensure evaluation of network adequacy includes measuring access for all Status 1 providers. Refer to the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2.*

### *Recommendations*

- Consider adding an adult medicine practitioner, such as a Family Practitioner or Internist, to the Credentialing Committee's membership.
- Revise the website to include the required statement that some providers may choose not to perform certain services based on religious or moral beliefs. Ideally, this should be on the landing page for the online Find a Provider tool or incorporated into the display of search results.

- Revise the Provider Manual to clearly define appointment access standards for specialists. Refer to the *SCDHHS Contract, Section 6.2.3.1.5.*

## C. Member Services

*42 CFR § 438.56, 42 CFR § 1212, 42 CFR § 438.100, 42 CFR § 438.10, 42 CFR 457.1220, 42 CFR § 457.1207, 42 CFR § 438.3 (j), 42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*

CCME's review of Member Services focused on areas such as member rights and responsibilities, member education and informational materials, Member Satisfaction Surveys, and grievance procedures and files. ATC has policies and procedures that define

and describe Member Services activities, and which provide guidance to staff for performing said activities.

Policy SC.MBRS.25, Member Rights and Responsibilities, describes how ATC advises members of their rights and responsibilities and how these rights are protected. The recent policy revision no longer includes the listing of member rights and responsibilities. Onsite discussions revealed staff members are trained to access the Member Handbook for a complete list of Member Rights and Responsibilities.

New members receive a Welcome Packet that includes information about accessing the Member Handbook and the Provider Directory, an identification card, member education materials, and enrollee rights. Policy SC.ELIG.17, Enrollment, does not indicate when ATC receives member enrollment data from SCDHHS; therefore, it is difficult to determine if members receive benefit information in writing within 14 days of ATC obtaining enrollment data, according to requirements in *SCDHHS Contract, Section 3.14.3*.

The Member Handbook provides useful information and is written at a 6th grade reading level, allowing it to be easily understood. It is available in Spanish and alternate formats including large font, audio, and Braille. The Member Handbook informs members of their rights and responsibilities, includes preventive health and appointment guidelines, and instructs members how to access benefits. The handbook is easily located on ATC's website.

The WholeYou member newsletters and health and wellness topics are readily accessible from the website. ATC ensures member program materials are written in a clear and understandable manner and meet contractual requirements.

Member Services staff are available per contract requirements via a toll-free number, which routes calls to Interactive Voice Response menus that allow callers to reach staff during the hours of 8:00 a.m. to 6:00 p.m. Eastern Standard Time, Monday through Friday. The Nurse Advice Line is available 24 hours a day.

ATC contracts with SPH Analytics, a certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey vendor to conduct both the Child and Adult Surveys. Survey results were presented to the Quality Improvement Committees and to providers. The number of completed surveys did not meet the National Committee for Quality Assurance (NCQA) requirement for the Adult Survey or the Child and Children with Chronic Conditions (CCC) Surveys. The Child CAHPS Survey response rate was 11.8%; the Adult CAHPS Survey response rate was 12.4%; and the Children with Chronic Conditions CAHPS Survey response rate was 14%. All response rates decreased from the 2019 and may impact the generalizability of the results. CCME recommends that ATC continue working with vendors to increase response rates.

## *Grievances*

*42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*

Requirements and processes for handling member grievances and complaints are found in policies and information is provided in the Member Handbooks, Provider Manual, and on the website. Grievance files reflect timely acknowledgement, resolution, and review by appropriate staff. Grievance resolution notices were timely and provided clear and concise information addressing the member's grievance and any follow-up that took place.

As noted in *Figure 5: Member Services Findings*, 100% of the standards for Member Services are scored as "Met."

**Figure 5: Member Services Findings**

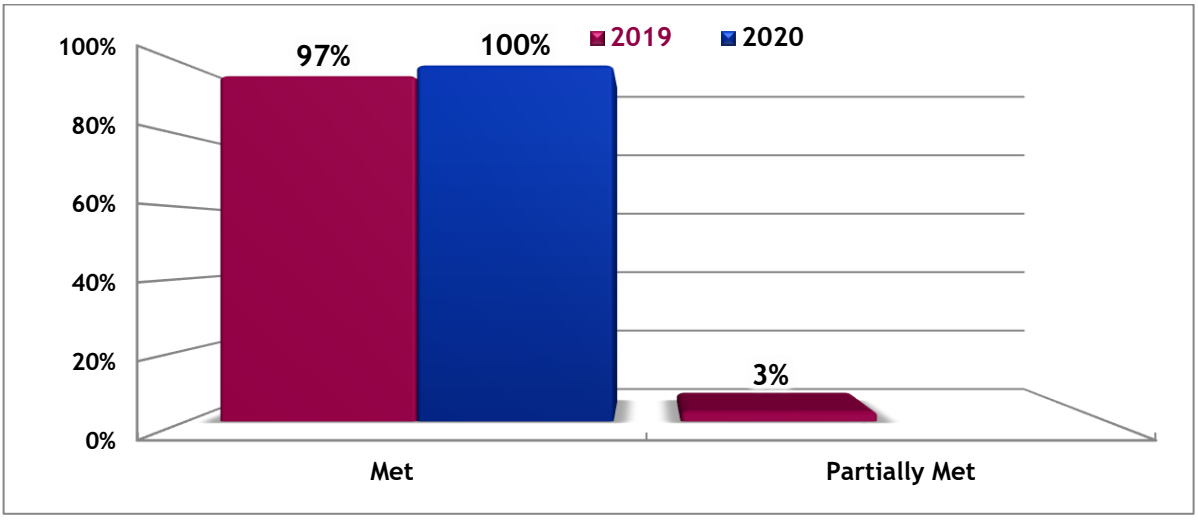



**Table 7: Member Services Comparative Data**

| SECTION | STANDARD | 2019 REVIEW | 2020 REVIEW |
|---|---|---|---|
| Grievances | The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to<br><br>Procedures for filing and handling a grievance | Partially Met | Met |

*The standards reflected in the table are only the standards that showed a change in score from 2019 to 2020.*

### *Strengths*

- The WholeYou member newsletters are easily accessible on the website. The newsletters are easy to navigate and contain information on many health topics, covering risk factors and wellness promotion, which varies with each edition.
- Grievance notices were timely and provides clear and concise information addressing the member's grievance and any follow-up that occurred.

### *Weaknesses*

- Policy SC.ELIG.17, Enrollment, does not indicate when ATC receives member enrollment data; thus, it is difficult to determine if benefit information is provided within 14 days as required by the *SCDHHS Contract, Section 3.14.3*.
- Member satisfaction survey response rates continue to fall below the National Committee for Quality Assurance target response rate of 40%.

### *Recommendations*

- Edit Policy SC.ELIG.17, Enrollment, to indicate when ATC receives member enrollment data from SCDHHS and to reflect that members receive benefit information in writing within 14 days, according to the *SCDHHS Contract, Section 3.14.3*.
- Continue working with SPH Analytics to increase response rates and identify methods to improve responses. Social media posts, text reminders (if possible), and reminders during call center interactions are encouraged to be continued.

## D. Quality Improvement

*42 CFR §438.330 and 42 CFR §457.1240(b)*

For the Quality Improvement (QI) section, CCME reviewed the 2020 Medicaid Quality Improvement Program Description, committee structure and minutes, performance measures, performance improvement projects, and the QI program evaluations. ATC provided the Absolute Total Care 2020 Quality Assessment and Performance Improvement Program Description Medicaid and Marketplace (QI Program Description) for review. Per the QI Program Description, ATC's primary goal is to ensure that all ATC's members have access to the highest quality of health care services that are responsive to their health needs and able to improve their health outcomes. Other goals include understanding members culture and languages, improving the continuity and coordination of medical and behavioral healthcare, and improving overall member and provider satisfaction.

The Work Plan is developed annually and facilitates improvement activities for the year. ATC provided the 3rd quarter 2019 and 3rd quarter 2020 Work Plans. All requirements for the Work Plan were met. Identified issues noted in the 2019 Work Plan were

appropriately addressed in the 2020 Work Plan. Some of those issues included: low number of quality-of-care referrals, low member attendance at the Member Advisory Council, and provider dissatisfaction. Interventions to address these issues were discussed in the Quality Improvement Committee meetings and tracked on the Work Plan.

The Quality Improvement Committee (QIC) is the decision-making body ultimately responsible for the implementation, coordination, and oversight of the QI Program. Each internal department participates and contributes to the program and works collaboratively on QI activities. The QIC includes ATC senior management staff, clinical staff, and network practitioners. A quorum must be present to conduct the meeting. A minimum of 3 voting members including a senior executive, one ATC staff, and one external practitioner must be present for a quorum. Last year, CCME recommended that ATC recruit additional voting members for this committee due to some members not meeting ATC's attendance requirements. To address this recommendation, ATC decided to remove the attendance requirement while ensuring that each department was represented at each meeting. As stated above, a quorum must be met to conduct the meetings; therefore, ATC felt removing the attendance requirement would not jeopardize having enough voting members present.

ATC profiles the quality of care delivered by high-volume PCPs to improve compliance with practice guidelines and clinical performance indicators.

ATC indicated that due to COVID-19 and NCQA guidance to rotate rates if necessary during the HEDIS 2020 (MY2019) hybrid project, ATC did not have audited rates to send out to providers in the provider report cards, so report cards were not sent in CY 2020.

Annually, ATC evaluates the overall effectiveness of the QI Program and reports this evaluation to the Board of Directors and to the Quality Improvement Committee. The Quality Assessment and Performance Improvement Program Evaluation Medicaid and Marketplace - 2019 addressed all aspects of the QI Program.

### *Performance Measure Validation*

*42 CFR §438.330 (c) and §457.1240 (b)*

CCME conducted a validation review of the HEDIS measures following Centers for Medicare & Medicaid Services (CMS) protocols. This process assessed the production of these measures by the health plan to confirm reported information was valid. The performance measure validation found that ATC was fully compliant with all HEDIS measures and met the requirements per *42 CFR §438.330 (c) and §457.1240 (b)*.

*Table 8: HEDIS Performance Measure Results* reports all relevant HEDIS performance measures for ATC for the current review year, HEDIS 2020, the previous year (HEDIS

2019), and the change from 2019 to 2020. The change in rates displayed in green indicates a substantial (>10%) improvement.

**Table 8: HEDIS Performance Measure Results**

| MEASURE/DATA ELEMENT | HEDIS 2019 | HEDIS 2020 | PERCENTAGE POINT DIFFERENCE |
|---|---|---|---|
| **Effectiveness of Care: Prevention and Screening** | | | |
| Adult BMI Assessment (aba) | 87.59% | 87.35% | -0.24% |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc) | | | |
| *BMI Percentile* | 84.18% | 87.59% | 3.41% |
| *Counseling for Nutrition* | 67.40% | 72.26% | 4.86% |
| *Counseling for Physical Activity* | 64.72% | 67.40% | 2.68% |
| Childhood Immunization Status (cis) | | | |
| *DTaP* | 72.26% | 72.26% | 0.00% |
| *IPV* | 90.75% | 90.75% | 0.00% |
| *MMR* | 87.59% | 87.59% | 0.00% |
| *HiB* | 82.48% | 82.48% | 0.00% |
| *Hepatitis B* | 90.27% | 90.27% | 0.00% |
| *VZV* | 86.62% | 86.62% | 0.00% |
| *Pneumococcal Conjugate* | 78.35% | 78.35% | 0.00% |
| *Hepatitis A* | 85.16% | 85.16% | 0.00% |
| *Rotavirus* | 73.97% | 73.97% | 0.00% |
| *Influenza* | 39.90% | 39.90% | 0.00% |
| *Combination #2* | 67.88% | 67.88% | 0.00% |
| *Combination #3* | 65.94% | 65.94% | 0.00% |
| *Combination #4* | 64.96% | 64.96% | 0.00% |
| *Combination #5* | 57.18% | 57.18% | 0.00% |
| *Combination #6* | 32.85% | 32.85% | 0.00% |
| *Combination #7* | 56.69% | 56.69% | 0.00% |
| *Combination #8* | 32.60% | 32.60% | 0.00% |
| *Combination #9* | 28.95% | 28.95% | 0.00% |
| *Combination #10* | 28.71% | 28.71% | 0.00% |
| Immunizations for Adolescents (ima) | | | |
| *Meningococcal* | 74.45% | 72.02% | -2.43% |
| *Tdap/Td* | 84.91% | 82.00% | -2.91% |
| *Combination #1* | 73.72% | 71.05% | -2.67% |
| *Combination #2* | 30.66% | 31.39% | 0.73% |
| Human Papillomavirus Vaccine for Female Adolescents (hpv) | 32.36% | 32.36% | 0.00% |

| MEASURE/DATA ELEMENT | HEDIS 2019 | HEDIS 2020 | PERCENTAGE POINT DIFFERENCE |
|---|---|---|---|
| Lead Screening in Children (lsc) | 69.13% | 68.35% | -0.78% |
| Breast Cancer Screening (bcs) | 64.56% | 62.64% | -1.92% |
| Cervical Cancer Screening (ccs) | 65.94% | 65.94% | 0.00% |
| Chlamydia Screening in Women (chl) | | | |
| *16-20 Years* | 57.14% | 59.55% | 2.41% |
| *21-24 Years* | 66.24% | 66.48% | 0.24% |
| *Total* | 59.65% | 61.47% | 1.82% |
| **Effectiveness of Care: Respiratory Conditions** | | | |
| Appropriate Testing for Children with Pharyngitis (cwp) | | | |
| *3-17 years* | NR | 83.27% | NA |
| *18-64* | NR | 71.60% | NA |
| *65+* | NR | 70.59% | NA |
| *Total* | 79.47% | 81.09% | 1.62% |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr) | 21.86% | 26.65% | 4.79% |
| Pharmacotherapy Management of COPD Exacerbation (pce) | | | |
| *Systemic Corticosteroid* | 66.50% | 63.22% | -3.28% |
| *Bronchodilator* | 78.33% | 78.11% | -0.22% |
| Medication Management for People With Asthma (mma) | | | |
| *5-11 Years - Medication Compliance 50%* | 50.70% | 51.10% | 0.40% |
| *5-11 Years - Medication Compliance 75%* | 24.27% | 24.28% | 0.01% |
| *12-18 Years - Medication Compliance 50%* | 45.36% | 50.64% | 5.28% |
| *12-18 Years - Medication Compliance 75%* | 23.30% | 27.02% | 3.72% |
| *19-50 Years - Medication Compliance 50%* | 56.11% | 60.50% | 4.39% |
| *19-50 Years - Medication Compliance 75%* | 29.44% | 33.00% | 3.56% |
| *51-64 Years - Medication Compliance 50%* | 71.67% | 75.86% | 4.19% |
| *51-64 Years - Medication Compliance 75%* | 50.00% | 44.83% | -5.17% |
| *Total - Medication Compliance 50%* | 50.44% | 53.44% | 3.00% |
| *Total - Medication Compliance 75%* | 25.73% | 27.48% | 1.75% |
| Asthma Medication Ratio (amr) | | | |
| *5-11 Years* | 83.04% | 79.72% | -3.32% |
| *12-18 Years* | 72.66% | 71.72% | -0.94% |
| *19-50 Years* | 54.43% | 60.16% | 5.73% |
| *51-64 Years* | 60.71% | 61.84% | 1.13% |
| *Total* | 73.84% | 72.68% | -1.16% |
| **Effectiveness of Care: Cardiovascular Conditions** | | | |
| Controlling High Blood Pressure (cbp) | 46.47% | 50.85% | 4.38% |
| Persistence of Beta-Blocker Treatment After a Heart Attack (pbh) | 80.43% | 79.37% | -1.06% |
| Statin Therapy for Patients With Cardiovascular Disease (spc) | | | |

| MEASURE/DATA ELEMENT | HEDIS 2019 | HEDIS 2020 | PERCENTAGE POINT DIFFERENCE |
|---|---|---|---|
| *Received Statin Therapy - 21-75 years (Male)* | 77.49% | 79.47% | 1.98% |
| *Statin Adherence 80% - 21-75 years (Male)* | 50.84% | 59.41% | 8.57% |
| *Received Statin Therapy - 40-75 years (Female)* | 72.73% | 80.46% | 7.73% |
| *Statin Adherence 80% - 40-75 years (Female)* | 50.66% | 63.97% | 13.31% |
| *Received Statin Therapy - Total* | 75.23% | 79.94% | 4.71% |
| *Statin Adherence 80% - Total* | 50.76% | 61.58% | 10.82% |
| **Effectiveness of Care: Diabetes** | | | |
| Comprehensive Diabetes Care (cdc) | | | |
| *Hemoglobin A1c (HbA1c) Testing* | 89.29% | 91.06% | 1.77% |
| *HbA1c Poor Control (>9.0%)* | 42.34% | 41.42% | -0.92% |
| *HbA1c Control (<8.0%)* | 48.91% | 49.27% | 0.36% |
| *Eye Exam (Retinal) Performed* | 57.91% | 57.85% | -0.06% |
| *Medical Attention for Nephropathy* | 90.79% | 91.42% | 0.63% |
| *Blood Pressure Control (<140/90 mm Hg)* | 44.04% | 55.66% | 11.62% |
| Statin Therapy for Patients With Diabetes (spd) | | | |
| *Received Statin Therapy* | 60.74% | 68.25% | 7.51% |
| *Statin Adherence 80%* | 45.55% | 60.30% | 14.75% |
| **Effectiveness of Care: Musculoskeletal Conditions** | | | |
| Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art) | 67.23% | NR | NA |
| **Effectiveness of Care: Behavioral Health** | | | |
| Antidepressant Medication Management (amm) | | | |
| *Effective Acute Phase Treatment* | 41.32% | 43.12% | 1.80% |
| *Effective Continuation Phase Treatment* | 25.10% | 26.38% | 1.28% |
| Follow-Up Care for Children Prescribed ADHD Medication (add) | | | |
| *Initiation Phase* | 53.06% | 44.08% | -8.98% |
| *Continuation and Maintenance (C&M) Phase* | 63.59% | 59.46% | -4.13% |
| Follow-Up After Hospitalization for Mental Illness (fuh) | | | |
| *6-17 years - 30-Day Follow-Up* | 79.17% | 70.48% | -8.69% |
| *6-17 years - 7-Day Follow-Up* | 40.63% | 45.18% | 4.55% |
| *18-64 years - 30-Day Follow-Up* | 50.53% | 47.86% | -2.67% |
| *18-64 years - 7-Day Follow-Up* | 24.73% | 27.78% | 3.05% |
| *65+ years - 30-Day Follow-Up* | NA | NA | NA |
| *65+ years - 7-Day Follow-Up* | NA | NA | NA |
| *30-Day Follow-Up* | 55.40% | 53.48% | -1.92% |
| *7-Day Follow-Up* | 27.43% | 31.67% | 4.24% |
| Follow-Up After Emergency Department Visit for Mental Illness (fum) | | | |

| MEASURE/DATA ELEMENT | HEDIS 2019 | HEDIS 2020 | PERCENTAGE POINT DIFFERENCE |
|---|---|---|---|
| *6-17 years - 30-Day Follow-Up* | 67.23% | 68.09% | 0.86% |
| *6-17 years - 7-Day Follow-Up* | 40.90% | 44.07% | 3.17% |
| *18-64 years - 30-Day Follow-Up* | 47.25% | 47.20% | -0.05% |
| *18-64 years - 7-Day Follow-Up* | 30.75% | 31.90% | 1.15% |
| *65+ years - 30-Day Follow-Up* | NA | NA | NA |
| *65+ years - 7-Day Follow-Up* | NA | NA | NA |
| *30-Day Follow-Up* | 56.67% | 55.47% | -1.20% |
| *7-Day Follow-Up* | 35.54% | 36.78% | 1.24% |
| Follow-Up After High-Intensity Care for Substance Use Disorder (fui) | | | |
| *13-17 years - 30-Day Follow-Up* | NR | NA | NA |
| *13-17 years - 7-Day Follow-Up* | NR | NA | NA |
| *18-64 years - 30-Day Follow-Up* | NR | 39.65% | NA |
| *18-64 years - 7-Day Follow-Up* | NR | 28.63% | NA |
| *65+ years - 30-Day Follow-Up* | NR | NA | NA |
| *65+ years - 7-Day Follow-Up* | NR | NA | NA |
| *Total - 30-Day Follow-Up* | NR | 40.71% | NA |
| *Total - 7-Day Follow-Up* | NR | 29.25% | NA |
| Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua) | | | |
| *30-Day Follow-Up: 13-17 Years** | 12.90% | NA | NA |
| *7-Day Follow-Up: 13-17 Years** | 6.45% | NA | NA |
| *30-Day Follow-Up: 18+ Years* | 13.48% | 11.91% | -1.57% |
| *7-Day Follow-Up: 18+ Years* | 9.43% | 7.19% | -2.24% |
| *30-Day Follow-Up: Total* | 13.43% | 11.81% | -1.62% |
| *7-Day Follow-Up: Total* | 9.20% | 7.09% | -2.11% |
| Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd) | 75.19% | 76.71% | 1.52% |
| Diabetes Monitoring for People With Diabetes and Schizophrenia (smd) | 61.93% | 72.88% | 10.95% |
| Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)* | 47.83% | 75.00% | 27.17% |
| Pharmacotherapy for Opioid Use Disorder (pod) | | | |
| *16-64 years* | NR | 48.69% | NA |
| *65+ years* | NR | NA | NA |
| *Total* | NR | 48.38% | NA |
| Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa) | 62.93% | 64.11% | 1.18% |
| Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm) | | | |
| *Blood glucose testing - 1-11 Years* | NR | 41.51% | NA |
| *Cholesterol Testing - 1-11 Years* | NR | 28.30% | NA |
| *Blood glucose and Cholesterol Testing - 1-11 Years* | NR | 25.47% | NA |

| MEASURE/DATA ELEMENT | HEDIS 2019 | HEDIS 2020 | PERCENTAGE POINT DIFFERENCE |
|---|---|---|---|
| *Blood glucose testing - 12-17 Years* | NR | 51.85% | NA |
| *Cholesterol Testing - 12-17 Years* | NR | 30.16% | NA |
| *Blood glucose and Cholesterol Testing - 12-17 Years* | NR | 24.87% | NA |
| *Blood glucose testing - Total* | NR | 48.14% | NA |
| *Cholesterol Testing - Total* | NR | 29.49% | NA |
| *Blood glucose and Cholesterol Testing - Total* | NR | 25.08% | NA |
| **Effectiveness of Care: Medication Management** | | | |
| Annual Monitoring for Patients on Persistent Medications (mpm) | | | |
| *ACE Inhibitors or ARBs* | 88.29% | NR | NA |
| *Diuretics* | 88.89% | NR | NA |
| *Total* | 88.57% | NR | NA |
| **Effectiveness of Care: Overuse/Appropriateness** | | | |
| Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs) | 2.22% | 1.90% | -0.32% |
| Appropriate Treatment for Children With URI (uri) | | | |
| *3months-17 Years* | NR | 88.19% | NA |
| *18-64 Years* | NR | 67.54% | NA |
| *65+ Years* | NR | 46.63% | NA |
| *Total* | NR | 85.17% | NA |
| Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab) | | | |
| *3 months-17 Years* | NR | 57.45% | NA |
| *18-64 Years* | NR | 34.23% | NA |
| *65+ Years* | NR | 24.16% | NA |
| *Total* | NR | 49.22% | NA |
| Use of Imaging Studies for Low Back Pain (lbp) | 65.52% | 69.69% | 4.17% |
| Use of Opioids at High Dosage (hdo) | 4.65% | 2.71% | -1.94% |
| Use of Opioids From Multiple Providers (uop) | | | |
| *Multiple Prescribers* | 17.64% | 17.96% | 0.32% |
| *Multiple Pharmacies* | 7.78% | 5.55% | -2.23% |
| *Multiple Prescribers and Multiple Pharmacies* | 2.91% | 2.33% | -0.58% |
| Risk of Continued Opioid Use (cou) | | | |
| *18-64 years - >=15 Days covered* | 2.59% | 4.02% | 1.43% |
| *18-64 years - >=31 Days covered* | 1.01% | 2.18% | 1.17% |
| *65+ years - >=15 Days covered* | NA | 16.12% | NA |
| *65+ years - >=31 Days covered* | NA | 7.21% | NA |
| *Total - >=15 Days covered* | 2.59% | 5.39% | 2.80% |

| MEASURE/DATA ELEMENT | HEDIS 2019 | HEDIS 2020 | PERCENTAGE POINT DIFFERENCE |
|---|---|---|---|
| *Total - >=31 Days covered* | 1.01% | 2.75% | 1.74% |
| **Access/Availability of Care** | | | |
| Adults' Access to Preventive/Ambulatory Health Services (aap) | | | |
| *20-44 Years* | 76.47% | 76.92% | 0.45% |
| *45-64 Years* | 85.16% | 85.35% | 0.19% |
| *65+ Years** | 100% | 91.79% | -8.21% |
| *Total* | 79.17% | 81.93% | 2.76% |
| Children and Adolescents' Access to Primary Care Practitioners (cap) | | | |
| *12-24 Months* | 96.55% | 96.92% | 0.37% |
| *25 Months - 6 Years* | 85.33% | 85.93% | 0.60% |
| *7-11 Years* | 88.13% | 88.57% | 0.44% |
| *12-19 Years* | 86.86% | 86.82% | -0.04% |
| Initiation and Engagement of AOD Dependence Treatment (iet) | | | |
| *Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years** | NA | NA | NA |
| *Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years** | NA | NA | NA |
| *Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years** | NA | NA | NA |
| *Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years** | NA | NA | NA |
| *Other drug abuse or dependence: Initiation of AOD Treatment: 13-17 Years* | 35.34% | 32.64% | -2.70% |
| *Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years* | 23.31% | 15.28% | -8.03% |
| *Initiation of AOD Treatment: 13-17 Years* | 34.69% | 33.33% | -1.36% |
| *Engagement of AOD Treatment: 13-17 Years* | 21.77% | 15.38% | -6.39% |
| *Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years* | 44.78% | 40.55% | -4.23% |
| *Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years* | 9.20% | 7.21% | -1.99% |
| *Opioid abuse or dependence: Initiation of AOD Treatment: 18+ Years* | 39.50% | 43.93% | 4.43% |
| *Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years* | 14.25% | 19.08% | 4.83% |
| *Other drug abuse or dependence: Initiation of AOD Treatment: 18+ Years* | 42.77% | 38.79% | -3.98% |
| *Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years* | 11.21% | 7.84% | -3.37% |
| *Initiation of AOD Treatment: 18+ Years* | 41.30% | 39.61% | -1.69% |
| *Engagement of AOD Treatment: 18+ Years* | 10.55% | 9.85% | -0.70% |
| *Alcohol abuse or dependence: Initiation of AOD Treatment: Total* | 44.44% | 40.45% | -3.99% |
| *Alcohol abuse or dependence: Engagement of AOD Treatment: Total* | 9.66% | 7.47% | -2.19% |
| *Opioid abuse or dependence: Initiation of AOD Treatment:* | 39.41% | 43.95% | 4.54% |

| MEASURE/DATA ELEMENT | HEDIS 2019 | HEDIS 2020 | PERCENTAGE POINT DIFFERENCE |
|---|---|---|---|
| *Total* | | | |
| *Opioid abuse or dependence: Engagement of AOD Treatment: Total* | 14.29% | 19.19% | 4.90% |
| *Other drug abuse or dependence: Initiation of AOD Treatment: Total* | 41.91% | 38.11% | -3.80% |
| *Other drug abuse or dependence: Engagement of AOD Treatment: Total* | 12.61% | 8.67% | -3.94% |
| *Initiation of AOD Treatment: Total* | 40.82% | 39.21% | -1.61% |
| *Engagement of AOD Treatment: Total* | 11.38% | 10.20% | -1.18% |
| Prenatal and Postpartum Care (ppc) | | | |
| *Timeliness of Prenatal Care* | 91.48% | 93.67% | 2.19% |
| *Postpartum Care* | 67.40% | 78.83% | 11.43% |
| Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app) | | | |
| *1-11 Years** | NR | 54.55% | NA |
| *12-17 Years* | 52.58% | 61.00% | 8.42% |
| *Total* | 52.52% | 58.71% | 6.19% |
| **Utilization** | | | |
| Well-Child Visits in the First 15 Months of Life (w15) | | | |
| *0 Visits* | 2.19% | 0.73% | -1.46% |
| *1 Visit* | .49% | 1.95% | 1.46% |
| *2 Visits* | 2.68% | 1.95% | -0.73% |
| *3 Visits* | 3.41% | 3.89% | 0.48% |
| *4 Visits* | 8.52% | 9.00% | 0.48% |
| *5 Visits* | 14.36% | 9.98% | -4.38% |
| *6+ Visits* | 68.37% | 72.51% | 4.14% |
| Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34) | 63.75% | 59.85% | -3.90% |
| Adolescent Well-Care Visits (awc) | 55.96% | 52.07% | -3.89% |

*Note*. * indicates small denominator; NR= not reported; NA= not applicable

ATC uses Inovalon, a certified software organization for calculation of HEDIS rates. The comparison from the 2019 rates to the 2020 rates revealed a strong increase (>10%) in several rates, including Statin Therapy Adherence for Patients with Cardiovascular Disease, Comprehensive Diabetes Care - Blood Pressure Control, Statin Adherence for Patients with Diabetes, Diabetes Monitoring for People with Diabetes and Schizophrenia, Cardiovascular Monitoring for People with Schizophrenia, and Postpartum Care. There were no measures with a substantial decline (>10%). *Table 9* highlights the HEDIS measures with substantial increases or decreases in rate from last year to the current year.

**Table 9: HEDIS Measures with Substantial Changes in Rates**

| MEASURE/DATA ELEMENT | HEDIS 2019 | HEDIS 2020 | Change from 2019 to 2020 |
|---|---|---|---|
| **Substantial Increase in Rate (>10% improvement)** | | | |
| Statin Therapy for Patients With Cardiovascular Disease (spc) | | | |
| *Statin Adherence 80% - 40-75 years (Female)* | 50.66% | 63.97% | 13.31% |
| *Statin Adherence 80% - Total* | 50.76% | 61.58% | 10.82% |
| Comprehensive Diabetes Care (cdc) | | | |
| *Blood Pressure Control (<140/90 mm Hg)* | 44.04% | 55.66% | 11.62% |
| Statin Therapy for Patients With Diabetes (spd) | | | |
| *Statin Adherence 80%* | 45.55% | 60.30% | 14.75% |
| *Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)* | 61.93% | 72.88% | 10.95% |
| *Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)** | 47.83% | 75.00% | 27.17% |
| Prenatal and Postpartum Care (ppc) | | | |
| *Postpartum Care* | 67.40% | 78.83% | 11.43% |

## *Quality Withhold Measures*

As required by SCDHHS, there were 16 quality clinical withhold measures reported for 2019. The Behavioral Health measures are considered Bonus Only for MY 2019 (reporting year 2020). As per the Medicaid Playbook and *Policy and Procedure Guide for Managed Care Organizations*, individual measures within quality index are weighted differently. A point value is assigned for each measure based on percentile (<10 percentile = 1 point; 10-24 percentile = 2 points; 25-49 percentile = 3 points; 50-74 percentile = 4 points; 75-90 percentile = 5 points; >90 percentile = 6 points). Points attained for each measure are multiplied by individual measure's weights then summed to obtain quality index score. *Table 10: Quality Withhold Measures* shows the 2019 rate, percentile, point value, and index score. The Women's Health measure rates generated the highest index score, followed by Diabetes, and then Pediatric Preventive Care. The Behavioral Health index score reflected an index score of 2.25.

**Table 10: Quality Withhold Measures**

| Measure | MY 2019 Rate | MY 2019 Percentile | Point Value | Index Score |
|---|---|---|---|---|
| DIABETES | | | | |
| Hemoglobin A1c (HbA1c) Testing | 89.29 | 90 | 6 | 4.9 |
| HbA1c Control (< =9) | 42.34 | 50 | 4 | |
| Eye Exam (Retinal) Performed | 57.91 | 75 | 5 | |
| Medical Attention for Nephropathy | 90.79 | 50 | 4 | |
| WOMEN'S HEALTH | | | | |
| Timeliness of Prenatal Care | 93.67 | 90 | 6 | 5.1 |
| Breast Cancer Screen | 62.64 | 75 | 5 | |
| Cervical Cancer Screen | 65.94 | 75 | 5 | |
| Chlamydia Screen in Women (Total) | 61.47 | 50 | 4 | |
| PEDIATRIC PREVENTIVE CARE | | | | |
| 6+ Well-Child Visits in First 15 months of Life | 72.51 | 75 | 5 | 3.3 |
| Well Child Visits in 3rd, 4th, 5th & 6th Years of Life | 63.75 | 10 | 2 | |
| Adolescent Well-Care Visits | 55.96 | 25 | 3 | |
| Weight Assessment/Adolescents: BMI % Total | 87.59 | 75 | 5 | |
| BEHAVIORAL HEALTH | | | | |
| FUH - Follow-Up After Hospitalization for Mental Illness - 7 Days | 32.33 | 50 | 4 | 2.25 |
| IET - Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Initiation – Total | 39.22 | 25 | 3 | |
| ADD- Follow Up for Children Prescribed ADHD Medication – Initiation | 44.08 | 25 | 3 | |
| AMM - Continuation Phase-Antidepressant Medication Management - 180 Days (6 Months) | 23.13 | <10 | 1 | |
| APM- Metabolic Monitoring for Children & Adolescents on Antipsychotics - Total | 25.08 | 10 | 2 | |
| APP- Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics - Total | 58.71 | 25 | 3 | |

ATC's HEDIS Steering Committee met regularly to review monthly administrative results, review initiatives for effectiveness, and implement new or change current initiatives. Some of the initiatives included member and provider outreach and educations, scheduling of member appointments to close gaps in care, and expanding access to medical records and data feeds.

### *Performance Improvement Project Validation*

*42 CFR §438.330 (d) and §457.1240 (b)*

The validation of the Performance Improvement Projects (PIPs) was done in accordance with the CMS-developed protocol titled, *EQR Protocol 1: Validating Performance Improvement Projects*. The protocol validates project components and its documentation to provide an assessment of the overall study design and project methodology. The components assessed include the following:

- Study topic(s)
- Study question(s)
- Study indicator(s)
- Identified study population
- Sampling methodology (if used)
- Data collection procedures
- Improvement strategies

ATC submitted three projects for validation: Postpartum Care, Provider Satisfaction, and Hospital Readmissions. *Table 11: Performance Improvement Project Validation Scores* provides an overview of the previous year's validation scores with the current scores.

**TABLE 11: Performance Improvement Project Validation Scores**

| Project | 2019 Validation Score | 2020 Validation Score |
|---|---|---|
| Postpartum Care | 98/98=100%<br>High Confidence in Reported Results | 100/100=100%<br>High Confidence in Reported Results |
| Provider Satisfaction | 87/88=99%<br>High Confidence in Reported Results | Not validated due to a delay in conducting the Provider Satisfaction survey |
| Hospital Readmissions | Not validated/Not yet active | 72/72=100%<br>High Confidence in Reported Results |

The PIPs validated received scores within the High Confidence Range and met the validation requirements per *42 CFR §438.330 (d)* and *§457.1240 (b)*.

Last year, it was noted that the rate for the Provider Satisfaction PIP decreased from baseline. ATC indicated the provider satisfaction workgroup met and interventions were

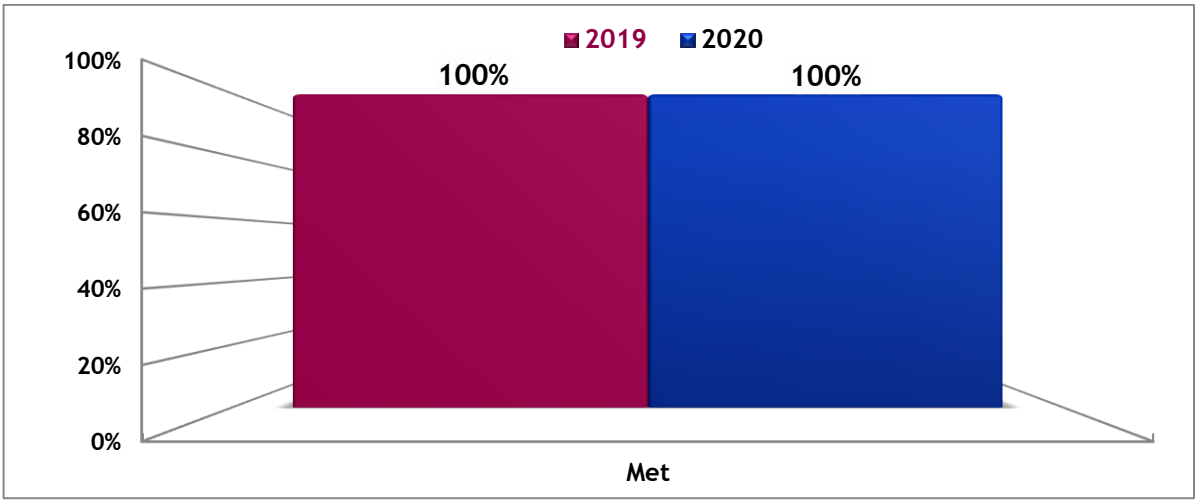
discussed. Those included additional staff training, the implementation of the Interpreta application that allows network providers to receive real-time care gap reports, and hosting regional provider meetings. To help improve provider satisfaction, CCME recommended ATC continue those interventions. For this EQR, CCME was unable to assess the effectiveness of those interventions because the provider satisfaction survey was delayed and the results were not available for this review. Staff did indicate that preliminary results showed some improvements.

The Postpartum Care and a new Readmissions PIP were validated during this EQR. The Postpartum Care PIP did show an improvement in the rate although it was still below the benchmark rate. Interventions for this PIP include pay for performance initiatives for providers, transportation and outreach education for members, the Interpreta platform for real time data, and a car seat initiative for members. The Readmissions PIP had baseline data only and therefore improvement could not be evaluated. There are several interventions underway for this PIP using ATC's Post Hospital Outreach Team to assess the member's needs before and after discharge, medication reconciliation with the primary care provider, and referrals to Case Management as needed.

Details of the validation of the performance measures and performance improvement projects can be found in the *CCME EQR Validation Worksheets, Attachment 3*.

ATC continued to meet all the standards in the QI section as noted in *Figure 6*.

**Figure 6: Quality Improvement Findings**




## *Strengths*

- The performance measure validation found that ATC was fully compliant.

- The HEDIS rates that showed a substantial increase included: Statin therapy for patients with cardiovascular disease, comprehensive diabetes care, blood pressure control, Statin adherence for patients with diabetes, diabetes monitoring for people with diabetes and schizophrenia, cardiovascular monitoring for people with schizophrenia, and postpartum care.
- All PIPs received validation scores in the "High Confidence Range."

## E. Utilization Management

*42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228, 42 CFR § 438.228,42 CFR § 438, Subpart F, 42 CFR § 457. 1260, 42 CFR § 208, 42 CFR § 457.1230 (c),42 CFR § 208, 42 CFR § 457.1230 (c)*

CCME's assessment of ATC's Utilization Management (UM) Program included UM policies and procedures, medical necessity determination processes, pharmacy requirements, the Care Management Program, ATC's website, and a review of approval, denial, appeal, and care management files. The UM Program Description and policies provide guidance to staff conducting UM activities for physical health, behavioral health, and pharmaceutical services for members in South Carolina.

Medical necessity reviews of service authorization requests are conducted using InterQual guidelines, ATC's internal clinical criteria, or other established criteria. ATC assesses consistency in criteria application and decision-making through annual inter-rater reliability (IRR) testing for physician and non-physician reviewers, and therapy, behavioral health, and pharmacy staff. All staff received passing scores of 90% or greater in their respective clinical areas. Review of approval and denial files reflect timely and consistent decision-making.

Envolve is delegated to provide pharmacy benefit services for ATC and uses the most current version of the PDL, which is accessible on the website. Pharmacy benefit information is available in policies such as Policy CC.PHAR.08, Pharmacy Prior Authorization and Medical Necessity Criteria, Policy SC.PHAR.09, Pharmacy Program, the Member Handbook, the website, and the Medicaid Provider Manual 2020. Policy CC.PHAR.10, Preferred Drug List Addendum, is specific to South Carolina; however, it describes processes for communicating negative PDL changes at the corporate level and state level, which are not clearly defined and are confusing. The PDL Updates posted on the website have several "effective" dates documented that make it difficult to determine when the updates are effective. CCME offered recommendations to address these issues.

ATC analyzed and monitored data for over/underutilization in several services, such as, Neonate Rates, Length of Stay, and ER Utilization. The plan offered recommendations

and action plans in committee meetings and in program evaluations based on results of their findings.

The Care Management and Care Coordination programs focus on prevention, continuity of care, and coordination of services. The Disease Management Program, administered by Envolve People Care, focuses on assisting the member to manage chronic medical conditions. ATC uses care management techniques to ensure comprehensive, coordinated care for all members in various risk levels and follows standards of the Case Management Society of America (CMSA). The CMSA definition of case management is inconsistently documented in the Case Management Program Description and in Policy SC.CM.02, Care Coordination/Care Management Services. CM files indicate care management activities are conducted as required and HIPAA verification, identifying care-gaps, and social determinants of health are consistently addressed.

### *Appeals*

*42 CFR § 438.228,42 CFR § 438, Subpart F, 42 CFR § 457.1260*

ATC has established policies defining processes for handling appeals of adverse benefit determinations that are consistent with requirements in the *SCDHHS Contract* and Federal Regulations. Standard appeals and resolution notices are provided within 30 calendar days of receipt and expedited appeals within 72 hours of receipt. Determination letters are written in language that is easily understood by a layperson and instructions for a State Fair Hearing are provided. CCME noted that instructions for requesting a State Fair Hearing reference the Notice of Resolution. However, the Appeal Upheld letter template does not indicate it is the Notice of Resolution and the reader may not understand it is the same.

Review of appeal files reflect timely acknowledgement, resolution, and notification of determination. Summaries of appeal actions, trends, and root causes are reported to the Utilization Management Committee and the Quality Improvement Committee and are used to identify opportunities to improve quality of care and service.

As noted in *Figure 7: Utilization Management Findings*, ATC achieved "Met" scores for 100% of the Utilization Management standards.

Figure 7: Utilization Management Findings

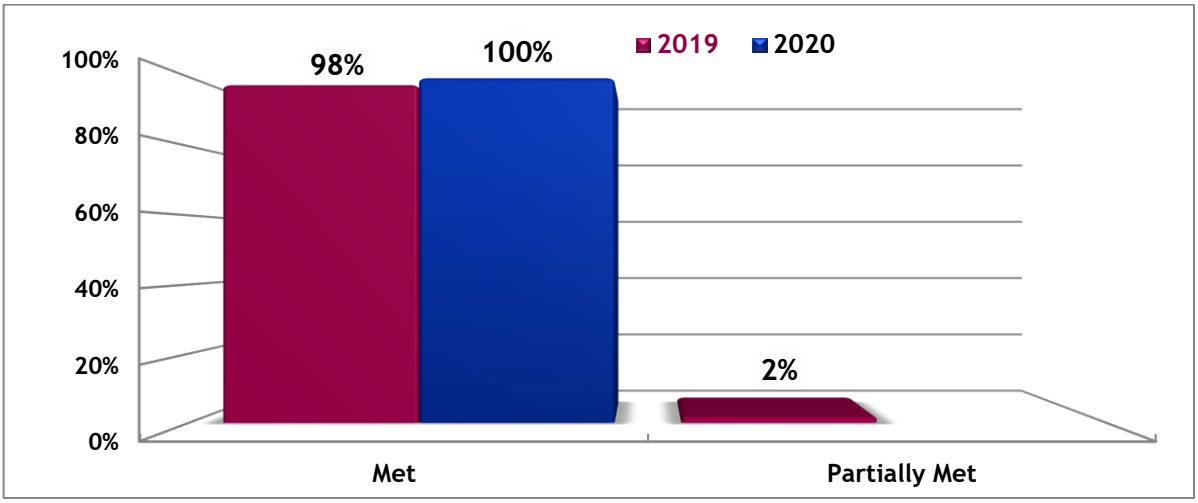



TABLE 12: Utilization Management Comparative Data

| SECTION | STANDARD | 2019 REVIEW | 2020 REVIEW |
|---|---|---|---|
| Pharmacy Requirements | Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts. | Partially Met | Met |

*The standards reflected in the table are only the standards that showed a change in score from 2019 to 2020.*

### *Strengths*

- UM Reviewers scored above the benchmark goal of 90% on annual inter-rater reliability tests.
- Determination letters are written in language that is easily understood by a layperson and medical terminology is explained, when used.

### *Weaknesses*

- Policy CC.PHAR.10, Preferred Drug List Addendum, is specific to South Carolina; however, it describes processes for communicating negative PDL changes at the corporate level and state level, which are not clearly defined and are confusing.
- The PDL Updates posted on the website have several "effective" dates documented, which makes it difficult to determine when the updates are truly effective.
- The "Notice of Your Right to a State Fair Hearing," enclosed with the Appeal Upheld letter, instructs the reader to send a copy of the notice of resolution. However, the

Appeal Upheld letter template does not have a reference or indication that it is also the notice of resolution and the reader may not understand that it is the same.

- The CMSA definition of case management is inconsistently documented on page six of the CM Program Description and on page 28 of Policy SC.CM.02, Care Coordination/Care Management Services.

### *Recommendations*

- Edit Policy CC.PHAR.10, Preferred Drug List Addendum, to clearly indicate ATC's SC-specific process for communicating negative PDL changes 30 days before the effective date and that changes are posted on the website in addition to notifying the impacted member and provider.
- Edit the Preferred Drug List Updates document to clearly indicate the effective date for the drugs listed.
- Consider including a heading or statement on the Appeal Upheld letter template to indicate it is also the Notice of Resolution.
- Ensure the definition of Case Management is consistently defined in the CM Program Description and Policy SC.CM.02. Care Coordination/Care Management Services.

## F. Delegation

*42 CFR § 438.230 and 42 CFR § 457.1233(b)*

CCME's review of delegation functions included the submitted delegate list, sample delegation contracts, delegation monitoring materials, and delegation oversight documentation.

ATC reported several current delegation agreements, as shown in *Table 13: Delegated Entities and Services*.

**Table 13: Delegated Entities and Services**

| Delegated Entities | Delegated Services |
|---|---|
| •AnMed Health<br>•AU Medical Center/AU Medical Associates (formerly Medical College of Georgia)<br>•Bons Secours Ambulatory Services – St. Francis LLC (dba AFC Urgent Care)<br>•CVS Caremark Minute Clinic<br>•Health Network Solutions<br>•Lexington Medical Center | Credentialing and Recredentialing |

| Delegated Entities | Delegated Services |
|---|---|
| •Management and Network Services Skilled Nursing Facility<br>•Medical University of South Carolina (MUSC)<br>•Preferred Care of Aiken<br>•Prisma Health (formerly Greenville Health System)<br>•Prisma Palmetto Health/University of South Carolina Medical Group<br>•Regional HealthPlus - Spartanburg<br>•Roper St. Francis Physicians Network<br>•St. Francis Physician Services, Inc (Bon Secours) | |
| •Envolve | 24 Hour Nurse Response Line<br>Disease Management<br>Pharmacy Benefit Management<br>Vision Services |
| •National Imaging Associates (NIA) | Imaging Network |

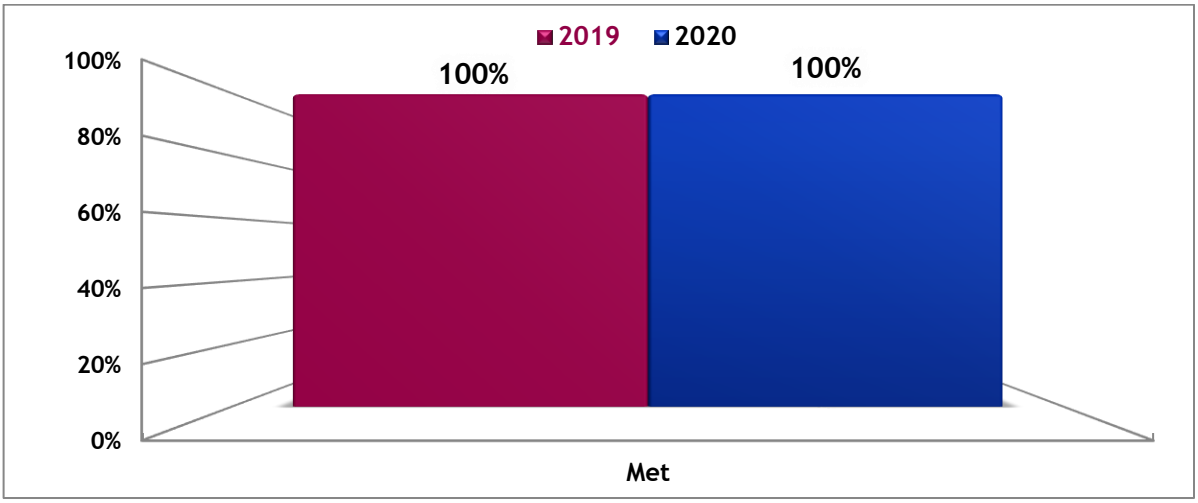
Per Policy CC.CRED.12, Oversight of Delegated Credentialing, and Policy SC.UM.18, Oversight of Delegated Utilization Management, ATC and/or Centene conducts a pre-delegation assessment of each potential delegate to determine the entity's ability to meet requirements for delegated functions. If the delegation is approved, a delegation agreement, signed by both parties, is executed. For all delegates, ongoing monitoring is conducted to ensure continued compliance with all requirements.

Ongoing compliance is monitored through annual auditing of each delegate along with quarterly Joint Operating Committee meetings. Additionally, delegates are required to submit reports of activities on a pre-defined schedule.

ATC submitted documentation of annual oversight and minutes from quarterly Joint Operating Committee meetings for each delegate. Review of this documentation confirms appropriate monitoring is conducted based on the delegated functions. For credentialing delegates, oversight and monitoring tools included all required credentialing and recredentialing elements. It was noted during onsite discussion that for credentialing delegates, ATC/Centene has assumed responsibility for queries of the Social Security Death Master File, as some delegates were having difficulty with gaining access to the information. For non-credentialing delegates, the oversight and monitoring tools included appropriate performance elements for the functions delegated. Identified deficiencies and applicable corrective actions were noted in the monitoring reports.

As noted in *Figure 8: Delegation Findings*, 100% of the delegation standards were scored as "Met."

**Figure 8: Delegation Findings**




### *Strengths*

- Delegation monitoring and oversight tools include appropriate elements for the type of delegation.

## G. State Mandated Services

*42 CFR Part 441, Subpart B*

CCME reviewed requirements for State Mandated Services. ATC continuously monitors immunization and Early and Periodic Screening Diagnostic, and Treatment (EPSDT) compliance through frequent review of HEDIS metrics and provider performance on medical record reviews. The health plan has several processes and provider engagement activities in place to educate, notify, and remind providers of needed EPSDT services. ATC ensures core benefits and services are provided to members as required by the *SCDHHS Contract* and *42 CFR Part 441, Subpart B.*

The plan is required to address deficiencies identified in the previous EQR. However, ATC did not include the following Status 1 provider types: General Surgery and Rehabilitative Behavioral Health on Geo Access mapping conducted on December 21, 2020. Failure to include all Status 1 provider types in Geo Access mapping was identified as an issue in the previous EQR.

ATC provides all core benefits specified by the *SCDHHS Contract*. *Figure 9: State Mandated Services* shows 75% of the State Mandated Services standards were met.

Figure 9: State Mandated Services

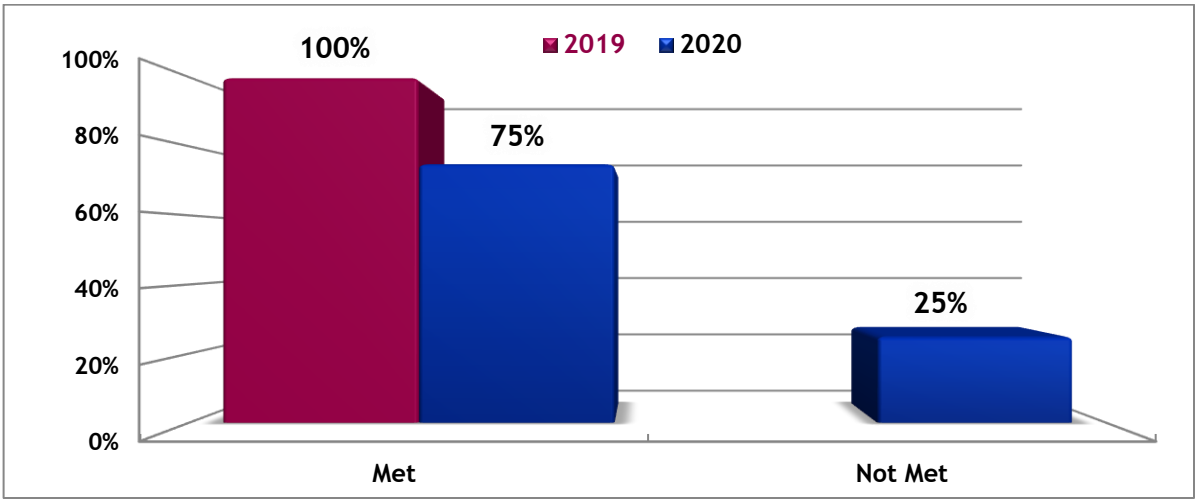



TABLE 14: State Mandated Comparative Data

| Section | Standard | 2019 Review | 2020 Review |
|---|---|---|---|
| State-Mandated Services | The MCO addresses deficiencies identified in previous independent external quality reviews | Met | Not Met |

*The standards reflected in the table are only the standards that showed a change in score from 2019 to 2020.*

### *Strengths*

- ATC provided all core benefits required by the *SCDHHS Contract*.

### *Weaknesses*

- Geo Access mapping conducted on December 21, 2020 did not include the following Status 1 Provider types: General Surgery and Rehabilitative Behavioral Health. This was an issue identified in the previous EQR.

### *Quality Improvement Plans*

- Develop and implement a monitoring process to ensure specifications for Geo Access mapping include all Status 1 providers as defined in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2*.

## ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Tabular Spreadsheet

## A. Attachment 1: Initial Notice, Materials Requested for Desk Review

December 7, 2020

Mr. John McClellan
President
Absolute Total Care
1441 Main Street, Suite 900
Columbia, SC 29201

Dear Mr. McClellan:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2020 External Quality Review (EQR) of Absolute Total Care is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with SCDHHS in relation to your organization's administration of a managed care program for the Healthy Connections Medicaid recipients.

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review. Due to COVID-19 the two day onsite previously performed at the health plan's office will be conducted virtually. The CCME EQR team plans to conduct the virtual onsite on **February 24th and 25th**.

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **December 21, 2020.**

To help with submission of the desk materials, we have set-up a secure file transfer site to allow health plans under review to submit desk materials directly to CCME thru the site. The file transfer site can be found at:

https://eqro.thecarolinascenter.org

I have included written instructions on how to use the file transfer site and would be happy to answer any questions on how to utilize the file transfer site if needed. An opportunity for a conference call with your staff, to describe the review process and answer any questions prior to the onsite visit, is being offered as well. Please contact me directly at 803-212-7582 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review

Enclosure
cc: SCDHHS

## External Quality Review 2020

### MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, as well as a complete index which includes policy name, number and department owner. The date of the addition/review/revision should be identifiable on each policy.

2. Organizational chart of all staff members including names of individuals in each position, and any current vacancies.

3. Current membership demographics including total enrollment and distribution by age ranges, sex, and county of residence.

4. Documentation of all service planning and provider network planning activities (e.g., copies of complete geographic assessments, provider network assessments, enrollee demographic studies, and population needs assessments) that support the adequacy of the provider base. Please include the maximum allowed and the current member-to-PCP ratios and member-to-specialist ratios.

5. A complete list of network providers for the Healthy Connections Choices (HCC) members. The list should be submitted as an excel spreadsheet in the format listed in the table below. Specialty codes and county codes may be used however please provide an explanation of the codes used by your organization.

Excel Spreadsheet Format

| List of Network Providers for Healthy Connections Choices Members | |
|---|---|
| Practitioner's First Name | Practitioner's Last Name |
| Practitioner's title (MD, NP, PA, etc.) | Phone Number |
| Specialty | Counties Served |
| Practice Name | Indicate Y/N if provider is accepting new patients |
| Practice Address | Age Restrictions |

6. The total number of unique specialty providers as well as the total number of unique primary care providers currently in the network.

7. A current provider list/directory as supplied to members.

8. A copy of the current Compliance plan and organization chart for the compliance department. Include the Fraud, Waste, and Abuse plan if a separate document has been developed, as well as any policies/procedures related to provider payment suspensions and recoupments of overpayments, and the pharmacy lock-in program.

9. A description of the Credentialing, Quality Improvement, Medical/Utilization Management, Disease/Case Management, and Pharmacy Programs.

10. The Quality Improvement work plans for 2019 and 2020.

11. The most recent reports summarizing the effectiveness of the Quality Improvement, Medical/Utilization Management, and Disease/Case Management Programs.

12. Documentation of all Performance Improvement Projects (PIPs) completed or planned since the previous Annual Review, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, analysis of results for each measurement period, barriers to improvement and interventions to address each barrier, statistical analysis (if sampling was used), etc.

13. Minutes of all committee meetings in the past year reviewing or taking action on SC Medicaid-related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory, rather than sending duplicate materials.

14. Membership lists and a committee matrix for all committees including the professional specialty of any non-staff members. Please indicate which members are voting members and include the committee charters if available.

15. Any data collected for the purposes of monitoring the utilization (over and under) of health care services.

16. Copies of the most recent physician profiling activities conducted to measure contracted provider performance.

17. Results of the most recent medical office site reviews, medical record reviews and a copy of the tools used to complete these reviews.

18. A complete list of all members enrolled in the case management program from December 2019 through November 2020. Please include open and closed case management files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.

19. A copy of staff handbooks/training manuals, orientation and educational materials and scripts used by Member Services Representatives and/or Call Center personnel.

20. A copy of the member handbook and any statement of the member bill of rights and responsibilities if not included in the handbook.

21. A report of findings from the most recent member and provider satisfaction survey, a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract, final report provided by the subcontractor, and other documentation of the requested scope of work.

22. A copy of any member and provider newsletters, educational materials and/or other mailings. Include new provider orientation and ongoing provider education materials.

23. A copy of the Grievance, Complaint and Appeal logs for the months of December 2019 through November 2020.

24. Copies of all letter templates for documenting approvals, denials, appeals, grievances and acknowledgements.

25. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal MCO compliance with these standards.

26. Preventive health practice guidelines recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

27. Clinical practice guidelines for disease and chronic illness management recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

28. A list of physicians currently available for utilization consultation/review and their specialty.

29. A copy of the provider handbook or manual.

30. A sample provider contract.

31. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in South Carolina, so if the health plan in South Carolina is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling South Carolina data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan or Business Continuity Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
    g. A copy of the most recent data security audit, if completed.
    h. A copy of the policies or program description that address the information systems security and access management. Please also include polices with respect to email and PHI.
    i. A copy of the Information Security Plan & Security Risk Assessment.

32. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the MCO, and any reports of activities submitted by the subcontractor to the MCO.

33. Sample contract used for delegated entities. Include a sample contract for each type of service delegated; i.e. credentialing, behavioral health, utilization management, external review, case/disease management, etc. Specific written agreements with subcontractors may be requested at the onsite review at CCME's discretion.

34. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used, and a copy of any tools used.
35. All HEDIS data and other performance and quality measures collected or planned. Required data and information include the following:
    **a. final HEDIS audit report**
    b. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen; hybrid methodology, including data sources and how the sample was chosen; or survey,

including a copy of the tool, how the sample was chosen and how the data was input), including a full description of the procedures;
c. reporting frequency and format;
d. specifications for all components used to identify the eligible population (e.g., member ID, age, sex, continuous enrollment calculation, clinical ICD/CPT codes, member months/years calculation, other specified parameters);
e. programming specifications that include data sources such as files/databases and fields with definitions, programming logic and computer source codes;
f. denominator calculations methodology, including:
    1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    2) specifications for all components used to identify the population for the denominator;
g. numerator calculations methodology, including:
    1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    2) specifications for all components used to identify the population for the numerator;
**h. calculated and reported rates.**
**i. Please include the Quality Compass percentile, point value, and index scores for the SCDHHS withhold measures.**

36. Provide electronic copies of the following files:
    a. Credentialing files (including signed Ownership Disclosure Forms) for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers;
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    b. Recredentialing (including signed Ownership Disclosure Forms) files for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    c. Twenty medical necessity denial files (acute inpatient, outpatient and behavioral health) made in the months of December 2019 through November 2020. Include any medical information and physician review documentations used in making the denial determination.
    d. Twenty-five utilization approval files (acute inpatient, outpatient and behavioral health) made in the months of December 2019 through November 2020, including any medical information and approval criteria used in the decision. Please include prior authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

*Note: Appeals, Grievances, and Care Coordination/Case Management files will be selected from the logs received with the desk materials. A request will then be sent to the plan to send electronic copies of the files to CCME.*

**These materials:**

- **should be organized and uploaded to the secure CCME EQR File Transfer site at:** https://eqro.thecarolinascenter.org

## B. Attachment 2: Materials Requested for Onsite Review

## External Quality Review 2020

### MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were submitted.
2. Please provide an explanation of where to locate the date the complete credentialing application was received in the initial credentialing files.
3. Copies of the Member and Provider Satisfaction workgroup meeting minutes. Please include the initiatives discussed and timeframes for implementation.
4. Provider Newsletters for 2020.
5. Copy of the Behavioral Health Adult ECHO survey results.
6. A copy of the print version of the Provider Directory, if available.
7. A copy of Policy SC.QI.05, Evaluation of the Accessibility of Services, or another policy that defines provider appointment access requirements.
8. Additional credentialing and recredentialing documentation noted on the attached "Items Needed for Credentialing and Recredentialing Files" list.

## C. Attachment 3: EQR Validation Worksheets

# CCME EQR PIP Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Absolute Total Care** |
| **Name of PIP:** | **HOSPITAL READMISSIONS - CLINICAL** |
| **Reporting Year:** | 2020 |
| **Review Performed:** | 2021 |

## ACTIVITY 1: ASSESS THE PIP METHODOLOGY

| Component / Standard (Total Points) | Score | Comments |
|---|---|---|
| **STEP 1: Review the Selected Study Topic(s)** | | |
| **1.1** Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)** | **MET** | Topic was selected through data collection. |
| **STEP 2: Review the PIP Aim Statement** | | |
| **2.1** Was the statement of PIP Aim(s) appropriate and adequate? **(10)** | **MET** | Aim of project was appropriate and documented. |
| **STEP 3: Identified PIP population** | | |
| **3.1** Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)** | **MET** | PIP addressed enrollee care and service. |
| **3.2** Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)** | **MET** | All enrolled populations are included. |
| **STEP 4: Review Sampling Methods** | | |
| **4.1** Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)** | **NA** | Sampling not used. |
| **4.2** Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:* | **NA** | Sampling not used. |
| **4.3** Did the sample contain a sufficient number of enrollees? **(5)** | **NA** | Sampling not used. |
| **STEP 5: Review Selected PIP Variables and Performance Measures** | | |
| **5.1** Did the study use objective, clearly defined, measurable indicators? **(10)** | **MET** | Measure was defined in report. |
| **5.2** Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)** | **MET** | Measure was focused on processes of care. |
| **STEP 6: Review Data Collection Procedures** | | |
| **6.1** Did the study design clearly specify the data to be collected? **(5)** | **MET** | Data to be collected were documented. |
| **6.2** Did the study design clearly specify the sources of data? **(1)** | **MET** | Data sources were listed. |

| Component / Standard (Total Points) | Score | Comments |
|---|---|---|
| **6.3** Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)** | **MET** | Data collection used dashboard and automated report. |
| **6.4** Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)** | **MET** | Consistent and accurate data was collected. |
| **6.5** Did the study design prospectively specify a data analysis plan? **(1)** | **MET** | Analysis was listed as annually with quarterly. |
| **6.6** Were qualified staff and personnel used to collect the data? **(5)** | **MET** | Detailed information regarding staff and personnel were provided in the report. |
| **STEP 7: Review Data Analysis and Interpretation of Study Results** | | |
| **7.1** Was an analysis of the findings performed according to the data analysis plan? **(5)** | **MET** | Analysis was conducted according to data analysis plan. |
| **7.2** Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)** | **MET** | Results were clearly presented. |
| **7.3** Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)** | **NA** | Baseline measurement only. |
| **7.4** Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)** | **MET** | Analysis of data is included in the report. |
| **STEP 8: Assess Improvement Strategies** | | |
| **8.1** Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)** | **MET** | Interventions were directly related to barriers identified. |
| **STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred** | | |
| **9.1** Was there any documented, quantitative improvement in processes or outcomes of care? **(1)** | **NA** | Baseline measurement only. |
| **9.2** Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)** | **NA** | Baseline measurement only. |
| **9.3** Is there any statistical evidence that any observed performance improvement is true improvement? **(1)** | **NA** | Baseline measurement only. |
| **9.4** Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)** | **NA** | Baseline measurement only. |

## ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

| Steps | Possible Score | Score |
|---|---|---|
| Step 1 | | |
| 1.1 | 5 | 5 |
| Step 2 | | |
| 2.1 | 10 | 10 |
| Step 3 | | |
| 3.1 | 1 | 1 |
| 3.2 | 1 | 1 |
| Step 4 | | |
| 4.1 | NA | NA |
| 4.2 | NA | NA |
| 4.3 | NA | NA |
| Step 5 | | |
| 5.1 | 10 | 10 |
| 5.2 | 1 | 1 |
| Step 6 | | |
| 6.1 | 5 | 5 |
| 6.2 | 1 | 1 |
| 6.3 | 1 | 1 |
| 6.4 | 5 | 5 |
| 6.5 | 1 | 1 |
| 6.6 | 5 | 5 |
| Step 7 | | |
| 7.1 | 5 | 5 |
| 7.2 | 10 | 10 |
| 7.3 | NA | NA |
| 7.4 | 1 | 1 |
| Step 8 | | |
| 8.1 | 10 | 10 |
| Step 9 | | |
| 9.1 | NA | NA |
| 9.2 | NA | NA |
| 9.3 | NA | NA |
| 9.4 | NA | NA |

| | |
|---|---|
| Project Score | 72 |
| Project Possible Score | 72 |
| Validation Findings | 100% |

| AUDIT DESIGNATION |
|---|
| HIGH CONFIDENCE IN REPORTED RESULTS |

| Audit Designation Categories | |
|---|---|
| **High Confidence in Reported Results** | Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.* |
| **Confidence in Reported Results** | Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.* |
| **Low Confidence in Reported Results** | Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.* |
| **Reported Results NOT Credible** | Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.* |

# CCME EQR PIP Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Absolute Total Care** |
| **Name of PIP:** | **POSTPARTUM CARE - CLINICAL** |
| **Reporting Year:** | 2020 |
| **Review Performed:** | 2021 |

## ACTIVITY 1: ASSESS THE PIP METHODOLOGY

| Component / Standard (Total Points) | Score | Comments |
|---|---|---|
| **STEP 1: Review the Selected Study Topic(s)** | | |
| **1.1** Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)** | **MET** | Topic was selected through data collection. |
| **STEP 2: Review the PIP Aim Statement** | | |
| **2.1** Was the statement of PIP Aim(s) appropriate and adequate? **(10)** | **MET** | Aim of project was appropriate and documented. |
| **STEP 3: Identified PIP population** | | |
| **3.1** Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)** | **MET** | PIP addressed enrollee care and service. |
| **3.2** Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)** | **MET** | All enrolled populations were included. |
| **STEP 4: Review Sampling Methods** | | |
| **4.1** Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)** | **MET** | HEDIS sampling specifications were used. |
| **4.2** Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:* | **MET** | HEDIS technique was valid. |
| **4.3** Did the sample contain a sufficient number of enrollees? **(5)** | **MET** | Sample size was sufficient. |
| **STEP 5: Review Selected PIP Variables and Performance Measures** | | |
| **5.1** Did the study use objective, clearly defined, measurable indicators? **(10)** | **MET** | Measure was defined in report. |
| **5.2** Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)** | **MET** | Measure was focused on processes of care and health status. |
| **STEP 6: Review Data Collection Procedures** | | |
| **6.1** Did the study design clearly specify the data to be collected? **(5)** | **MET** | Data to be collected were documented. |
| **6.2** Did the study design clearly specify the sources of data? **(1)** | **MET** | Data sources were listed. |

| Component / Standard (Total Points) | Score | Comments |
|---|---|---|
| **6.3** Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)** | **MET** | Data collection used programming logic according to HEDIS specifications. |
| **6.4** Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)** | **MET** | Consistent and accurate data were collected. |
| **6.5** Did the study design prospectively specify a data analysis plan? **(1)** | **MET** | Analysis is listed as annually with bi monthly monitoring. |
| **6.6** Were qualified staff and personnel used to collect the data? **(5)** | **MET** | Detailed information regarding staff and personnel were provided in the report. |
| **STEP 7: Review Data Analysis and Interpretation of Study Results** | | |
| **7.1** Was an analysis of the findings performed according to the data analysis plan? **(5)** | **MET** | Analysis was conducted according to data analysis plan. |
| **7.2** Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)** | **MET** | Results were clearly presented. |
| **7.3** Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)** | **MET** | Initial and repeat measurements were documented**.** |
| **7.4** Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)** | **MET** | Analysis of data was included in the report. |
| **STEP 8: Assess Improvement Strategies** | | |
| **8.1** Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)** | **MET** | Interventions were directly related to barriers identified. |
| **STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred** | | |
| **9.1** Was there any documented, quantitative improvement in processes or outcomes of care? **(1)** | **MET** | Rate improved from 66.42% to 67.40%. |
| **9.2** Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)** | **MET** | Rate does appear to be a result of the interventions. |
| **9.3** Is there any statistical evidence that any observed performance improvement is true improvement? **(1)** | **MET** | Statistical testing was conducted. |
| **9.4** Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)** | **NA** | Only 1 remeasurement, therefore unable to judge. |

## ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

| Steps | Possible Score | Score |
|---|---|---|
| **Step 1** | | |
| 1.1 | 5 | 5 |
| **Step 2** | | |
| 2.1 | 10 | 10 |
| **Step 3** | | |
| 3.1 | 1 | 1 |
| 3.2 | 1 | 1 |
| **Step 4** | | |
| 4.1 | 5 | 5 |
| 4.2 | 10 | 10 |
| 4.3 | 5 | 5 |
| **Step 5** | | |
| 5.1 | 10 | 10 |
| 5.2 | 1 | 1 |
| **Step 6** | | |
| 6.1 | 5 | 5 |
| 6.2 | 1 | 1 |
| 6.3 | 1 | 1 |
| 6.4 | 5 | 5 |
| 6.5 | 1 | 1 |
| 6.6 | 5 | 5 |
| **Step 7** | | |
| 7.1 | 5 | 5 |
| 7.2 | 10 | 10 |
| 7.3 | 1 | 1 |
| 7.4 | 1 | 1 |
| **Step 8** | | |
| 8.1 | 10 | 10 |
| **Step 9** | | |
| 9.1 | 1 | 1 |
| 9.2 | 5 | 5 |
| 9.3 | 1 | 1 |
| 9.4 | NA | NA |

| Project Score | 100 |
|---|---|
| Project Possible Score | 100 |
| Validation Findings | 100% |

| AUDIT DESIGNATION |
|---|
| HIGH CONFIDENCE IN REPORTED RESULTS |

| Audit Designation Categories | |
|---|---|
| **High Confidence in Reported Results** | Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.* |
| **Confidence in Reported Results** | Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.* |
| **Low Confidence in Reported Results** | Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.* |
| **Reported Results NOT Credible** | Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.* |

# CCME EQR PM Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Absolute Total Care** |
| **Name of PM:** | **ALL HEDIS MEASURES** |
| **Reporting Year:** | **2019** |
| **Review Performed:** | **2021** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| **HEDIS 2020** ***(Note: Due to COVID allowances, some hybrid rates for HEDIS 2020 were the same as RY2019/HEDIS 2019)*** |

| GENERAL MEASURE ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| G1 Documentation | Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes. | **Met** | Data sources and programming logic were documented. |

| DENOMINATOR ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| D1 Denominator | Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate. | **Met** | Denominator sources were accurate. |
| D2 Denominator | Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters). | **Met** | Calculation of rates adhered to denominator specifications. |

| NUMERATOR ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| N1 Numerator | Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate. | **Met** | Numerator sources were accurate. |

| NUMERATOR ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| N2 Numerator | Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters). | **Met** | Calculation of rates adhered to numerator specifications. |
| N3 Numerator–Medical Record Abstraction Only | If medical record abstraction was used, documentation/tools were adequate. | **Met** | Documentation and tools were found to be compliant. |
| N4 Numerator–Hybrid Only | If the hybrid method was used, the integration of administrative and medical record data was adequate. | **Met** | Integration methods were found to be compliant. |
| N5 Numerator - Medical Record Abstraction or Hybrid | If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator. | **Met** | Methods were reported to be compliant. |

| SAMPLING ELEMENTS (if Administrative Measure then N/A for section) | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| S1 Sampling | Sample treated all measures independently. | **Met** | Sampling was conducted according to specifications. |
| S2 Sampling | Sample size and replacement methodologies met specifications. | **Met** | Replacements were conducted and found compliant. |

| REPORTING ELEMENTS | | | |
|---|---|---|---|
| **Audit Elements** | **Audit Specifications** | **Validation** | **Comments** |
| R1 Reporting | Were the state specifications for reporting performance measures followed? | **Met** | HEDIS specifications were followed and found compliant. |
| **Overall assessment** | | | Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. Audit report noted compliance for HEDIS measures. |

| VALIDATION SUMMARY | | | |
|---|---|---|---|
| **Element** | **Standard Weight** | **Validation Result** | **Score** |
| G1 | 10 | Met | 10 |
| D1 | 10 | Met | 10 |
| D2 | 5 | Met | 5 |
| N1 | 10 | Met | 10 |
| N2 | 5 | Met | 5 |
| N3 | 5 | Met | 5 |
| N4 | 5 | Met | 5 |
| N5 | 5 | Met | 5 |
| S1 | 5 | Met | 5 |
| S2 | 5 | Met | 5 |
| R1 | 10 | Met | 10 |

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

| | |
|---|---|
| **Plan's Measure Score** | **75** |
| **Measure Weight Score** | **75** |
| **Validation Findings** | **100%** |

| AUDIT DESIGNATION |
|---|
| **FULLY COMPLIANT** |

| AUDIT DESIGNATION POSSIBILITIES | |
|---|---|
| **Fully Compliant** | Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.* |
| **Substantially Compliant** | Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.* |
| **Not Valid** | Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.* |
| **Not Applicable** | Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator. |

# CCME EQR Survey Validation Worksheet

| | |
|---|---|
| **Plan Name** | **Absolute Total Care** |
| **Survey Validated** | **CAHPS MEMBER SATISFACTION- ADULT** |
| **Validation Period** | 2020 |
| **Review Performed** | 2021 |

***Review Instructions***

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity. (updated based on October 2019 version of EQR protocol 6)

## ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND AUDIENCE

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **1.1** | Review whether there is a clear written statement of the survey's purpose(s). | **MET** | Survey purpose documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020 |
| **1.2** | Review that the study objectives are clear, measurable, and in writing. | **MET** | Study objective documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020 |
| **1.3** | Review that the intended use or audience(s) for the survey findings are identified. | **MET** | Survey audience identified in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020 |

## ACTIVITY 2: REVIEW THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **2.1** | Assess whether the survey was tested for face validity and content validity and found to be valid | **MET** | Survey tested for validity. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020 |
| **2.2** | Assess whether the survey instrument was tested for reliability and found to be reliable | **MET** | Survey tested for reliability. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020 |

## ACTIVITY 3: REVIEW THE SAMPLING PLAN

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **3.1** | Review that the definition of the study population was clearly identified. | **MET** | Study population was identified.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020 |
| **3.2** | Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives. | **MET** | Sampling frame was clearly defined and appropriate.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020 |
| **3.3** | Review that the sampling method appropriate to the survey purpose | **MET** | Sampling method was conducted according to specifications.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020 |
| **3.4** | Review whether the sample size is sufficient for the intended use of the survey. | **MET** | Sample size was sufficient according to CAHPS survey guidelines.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020 |
| **3.5** | Review that the procedures used to select the sample were appropriate and protected against bias. | **MET** | Procedures to select the sample were appropriate.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020 |

## ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **4.1** | Review the specifications for calculating response rates to make sure they are in accordance with industry standards | **MET** | The specifications for response rates were in accordance with standards.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020 |
| **4.2** | Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings. | **MET** | Response rate was reported and bias in generalizability was documented.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020 |

## ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **5.1** | Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits | **MET** | The quality plan was documented.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020 |
| **5.2** | Did the implementation of the survey follow the planned approach? | **MET** | Survey implementation followed the plan.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Adult 2020 |

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **5.3** | Were procedures developed to handle treatment of missing data or data determined to be unusable? | **MET** | Procedures for missing data were developed and applied.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020 |

## ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **6.1** | Was the survey data analyzed? | **MET** | Survey data were analyzed.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020 |
| **6.2** | Were appropriate statistical tests used and applied correctly? | **MET** | Appropriate tests were utilized.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020 |
| **6.3** | Were all survey conclusions supported by the data and analysis? | **MET** | Conclusions were supported by data analysis.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020 |

## ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

| Results Elements | | Validation Comments and Conclusions |
|---|---|---|
| **7.1** | Were procedures implemented to address responses that failed edit checks? | Procedures are in place to address response issues.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020 |
| **7.2** | Do the survey findings have any limitations or problems with generalization of the results? | The sample size was 1,881. The total completed surveys were 233 for a 12.4% response rate. This response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. The rate is below the previous year's rate of 17%.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020<br><br>***Recommendation:*** *Determine if there are any new barriers that caused a decrease in the number of completed surveys received for the Adult member population. Continue to work with SPH Analytics to improve response rates.* |
| **7.4** | What data analyzed according to the analysis plan laid out in the work plan? | Data was analyzed according to work plan.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020 |
| **7.5** | Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings? | The final report included a comprehensive overview of the survey purpose, implementation, and findings/results.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Adult 2020 |

# CCME EQR Survey Validation Worksheet

| | |
|---|---|
| **Plan Name** | **Absolute Total Care** |
| **Survey Validated** | **CAHPS MEMBER SATISFACTION- CHILD** |
| **Validation Period** | 2020 |
| **Review Performed** | 2021 |

***Review Instructions***

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity. (updated based on October 2019 version of EQR protocol 6)

## ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND AUDIENCE

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **1.1** | Review whether there is a clear written statement of the survey's purpose(s). | **MET** | Survey purpose documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2020 |
| **1.2** | Review that the study objectives are clear, measurable, and in writing. | **MET** | Study objective documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2020 |
| **1.3** | Review that the intended use or audience(s) for the survey findings are identified. | **MET** | Survey audience identified in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2020 |

## ACTIVITY 2: REVIEW THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **2.1** | Assess whether the survey was tested for face validity and content validity and found to be valid | **MET** | Survey tested for validity. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2020 |
| **2.2** | Assess whether the survey instrument was tested for reliability and found to be reliable | **MET** | Survey tested for reliability. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2020 |

## ACTIVITY 3: REVIEW THE SAMPLING PLAN

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **3.1** | Review that the definition of the study population was clearly identified. | **MET** | Study population was identified.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child 2020 |
| **3.2** | Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives. | **MET** | Sampling frame was clearly defined and appropriate.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child 2020 |
| **3.3** | Review that the sampling method appropriate to the survey purpose | **MET** | Sampling method was conducted according to specifications.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child 2020 |
| **3.4** | Review whether the sample size is sufficient for the intended use of the survey. | **MET** | Sample size was sufficient according to CAHPS survey guidelines.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child 2020 |
| **3.5** | Review that the procedures used to select the sample were appropriate and protected against bias. | **MET** | Procedures to select the sample were appropriate.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child 2020 |

## ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **4.1** | Review the specifications for calculating response rates to make sure they are in accordance with industry standards | **MET** | The specifications for response rates were in accordance with standards.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child 2020 |
| **4.2** | Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings. | **MET** | Response rate was reported and bias in generalizability was documented.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child 2020 |

## ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **5.1** | Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits | **MET** | The quality plan was documented.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child 2020 |
| **5.2** | Did the implementation of the survey follow the planned approach? | **MET** | Survey implementation followed the plan.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child 2020 |

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **5.3** | Were procedures developed to handle treatment of missing data or data determined to be unusable? | **MET** | Procedures for missing data were developed and applied.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child 2020 |

## ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **6.1** | Was the survey data analyzed? | **MET** | Survey data were analyzed.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child 2020 |
| **6.2** | Were appropriate statistical tests used and applied correctly? | **MET** | Appropriate tests were utilized.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child 2020 |
| **6.3** | Were all survey conclusions supported by the data and analysis? | **MET** | Conclusions were supported by data analysis.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child 2020 |

## ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

| Results Elements | | Validation Comments and Conclusions |
|---|---|---|
| **7.1** | Were procedures implemented to address responses that failed edit checks? | Procedures are in place to address response issues.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child 2020 |
| **7.2** | Do the survey findings have any limitations or problems with generalization of the results? | The sample size was 2,552. The total completed surveys was 302 for a 11.8% response rate. This response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. The rate is lower than the Book of Business average response rate of 12.8%.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child 2020<br><br>***Recommendation:*** *Determine if there are any new barriers that caused a decrease in the number of completed surveys received for the child population. Continue to work with SPH Analytics to improve response rates.* |
| **7.4** | What data analyzed according to the analysis plan laid out in the work plan? | Data was analyzed according to work plan.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child 2020 |
| **7.5** | Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings? | The final report included a comprehensive overview of the survey purpose, implementation, and findings/results.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child 2020 |

# CCME EQR Survey Validation Worksheet

| | |
|---|---|
| **Plan Name** | **Absolute Total Care** |
| **Survey Validated** | **CAHPS MEMBER SATISFACTION- CHILD CCC** |
| **Validation Period** | 2020 |
| **Review Performed** | 2021 |

***Review Instructions***

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity. (updated based on October 2019 version of EQR protocol 6)

## ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND AUDIENCE

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **1.1** | Review whether there is a clear written statement of the survey's purpose(s). | **MET** | Survey purpose documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020 |
| **1.2** | Review that the study objectives are clear, measurable, and in writing. | **MET** | Study objective documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020 |
| **1.3** | Review that the intended use or audience(s) for the survey findings are identified. | **MET** | Survey audience identified in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020 |

## ACTIVITY 2: REVIEW THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **2.1** | Assess whether the survey was tested for face validity and content validity and found to be valid | **MET** | Survey tested for validity. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020 |
| **2.2** | Assess whether the survey instrument was tested for reliability and found to be reliable | **MET** | Survey tested for reliability. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020 |

## ACTIVITY 3: REVIEW THE SAMPLING PLAN

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **3.1** | Review that the definition of the study population was clearly identified. | **MET** | Study population was identified.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020 |
| **3.2** | Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives. | **MET** | Sampling frame was clearly defined and appropriate.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020 |
| **3.3** | Review that the sampling method appropriate to the survey purpose | **MET** | Sampling method was conducted according to specifications.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020 |
| **3.4** | Review whether the sample size is sufficient for the intended use of the survey. | **MET** | Sample size was sufficient according to CAHPS survey guidelines.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020 |
| **3.5** | Review that the procedures used to select the sample were appropriate and protected against bias. | **MET** | Procedures to select the sample were appropriate.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020 |

## ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **4.1** | Review the specifications for calculating response rates to make sure they are in accordance with industry standards | **MET** | The specifications for response rates were in accordance with standards.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020 |
| **4.2** | Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings. | **MET** | Response rate was reported and bias in generalizability was documented.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020 |

## ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **5.1** | Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits | **MET** | The quality plan was documented.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020 |
| **5.2** | Did the implementation of the survey follow the planned approach? | **MET** | Survey implementation followed the plan.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2020 |

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **5.3** | Were procedures developed to handle treatment of missing data or data determined to be unusable? | **MET** | Procedures for missing data were developed and applied.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2020 |

## ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **6.1** | Was the survey data analyzed? | **MET** | Survey data were analyzed.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2020 |
| **6.2** | Were appropriate statistical tests used and applied correctly? | **MET** | Appropriate tests were utilized.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2020 |
| **6.3** | Were all survey conclusions supported by the data and analysis? | **MET** | Conclusions were supported by data analysis.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2020 |

## ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

| Results Elements | | Validation Comments and Conclusions |
|---|---|---|
| **7.1** | Were procedures implemented to address responses that failed edit checks? | Procedures are in place to address response issues.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2020 |
| **7.2** | Do the survey findings have any limitations or problems with generalization of the results? | The sample size was 1,647. The total completed surveys for the general population was 230 for a 14% response rate. This response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. The rate is lower than the previous year's rate of 18%.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2020<br><br>***Recommendation:*** *Determine if there are any new barriers that caused a decrease in the number of completed surveys received for the child population. Continue to work with SPH Analytics to improve response rates.* |
| **7.4** | What data analyzed according to the analysis plan laid out in the work plan? | Data was analyzed according to work plan.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2020 |
| **7.5** | Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings? | The final report included a comprehensive overview of the survey purpose, implementation, and findings/results.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2020 |

## D. Attachment 4: Tabular Spreadsheet

The Carolinas Center *for* Medical Excellence

# CCME MCO Data Collection Tool

| | |
|---|---|
| **Plan Name:** | Absolute Total Care |
| **Collection Date:** | 2020 |

## I. ADMINISTRATION

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| **I. ADMINISTRATION** | | | | | | |
| **I A. General Approach to Policies and Procedures** | | | | | | |
| 1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly. | X | | | | | |
| **I B. Organizational Chart / Staffing** | | | | | | |
| 1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles: | | | | | | A review of the ATC 2020 Organizational Chart indicates sufficient staff coverage is in place to meet the needs in contractually designated roles. |
| 1.1 *Administrator (Chief Executive Officer (CEO), Chief Operations Officer (COO), Executive Director (ED)); | X | | | | | John McClellan is ATC's President and CEO. |
| 1.2 Chief Financial Officer (CFO); | X | | | | | Stephen Moore is the Chief Financial Officer. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 1.3 * Contract Account Manager; | X | | | | | |
| 1.4 Information Systems Personnel; | | | | | | |
| 1.4.1 Claims and Encounter Manager/ Administrator, | X | | | | | The Senior Director and Supervisor of Claims Services is Cynthia Jones |
| 1.4.2 Network Management Claims and Encounter Processing Staff, | X | | | | | The Vice President of Network Development is Donald Pifer. |
| 1.5 Utilization Management (Coordinator, Manager, Director); | X | | | | | The Director, Utilization Management is Natalie Crumpton. |
| 1.5.1 Pharmacy Director, | X | | | | | Jenna Meisner is the Sr. Director of Pharmacy. |
| 1.5.2 Utilization Review Staff, | X | | | | | Onsite discussion revealed that UM staff are located in the Columbia and Charleston offices. |
| 1.5.3 *Case Management Staff, | X | | | | | Lee Jernigan is the Director of Case Management. |
| 1.6 *Quality Improvement (Coordinator, Manager, Director); | X | | | | | The Senior Vice President of Quality Improvement is Joyce McElwain. |
| 1.6.1 Quality Assessment and Performance Improvement Staff, | X | | | | | |
| 1.7 *Provider Services Manager; | X | | | | | K. Brown is the Senior Manager of Operations. |
| 1.7.1 *Provider Services Staff, | X | | | | | |
| 1.8 *Member Services Manager; | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 1.8.1 Member Services Staff, | X | | | | | |
| 1.9 *Medical Director; | X | | | | | Barry Lewis is the Chief Medical Director. |
| 1.10 *Compliance Officer; | X | | | | | Talvin Herbert is the VP of Compliance. |
| 1.10.1 Program Integrity Coordinator; | X | | | | | |
| 1.10.2 Compliance /Program Integrity Staff; | X | | | | | The Senior Compliance Manager is M. Luciano. |
| 1.11 * Interagency Liaison; | X | | | | | |
| 1.12 Legal Staff; | X | | | | | Onsite discussion indicated that Centene Legal Services is used as consultant to ATC. |
| 1.13 Board Certified Psychiatrist or Psychologist; | X | | | | | Dr. Frank Shelp is a board-certified Psychiatrist and is licensed by the South Carolina Board of Medical Examiners. |
| 1.14 Post-payment Review Staff. | X | | | | | |
| 2. Operational relationships of MCO staff are clearly delineated. | X | | | | | |
| **I C. Management Information Systems** *42 CFR § 438.242, 42 CFR § 457.1233 (d)* | | | | | | |
| 1. The MCO processes provider claims in an accurate and timely fashion. | X | | | | | ATC handles 98.6% of clean claims within 30 days. |
| 2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions. | X | | | | | ATC's systems are capable of handling HIPAA compliant electronic transactions. The MCO's ISCA documentation states 99% of transactions |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | are handled electronically. ATC also notes that a series of HIPAA validation checks are performed on data before it is loaded into its systems. |
| 3. The MCO tracks enrollment and demographic data and links it to the provider base. | X | | | | | ATC's ISCA documentation indicates the MCO has the capability of capturing information required by the State. Additionally, ATC noted that it verifies member eligibility and demographic data to ensure they match services required. |
| 4. The MCO's management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities. | X | | | | | ATC's IT systems and staff are capable of creating the HEDIS or HEDIS-like reports required by the State. Specifically, ATC uses an electronic data warehouse in conjunction with HEDIS-certified reporting software, Quality Spectrum Insights. |
| 5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract. | X | | | | | Absolute Total Care has the policies, procedures, and processes in place to address the data security requirements of *SCDHHS Contract*. A third-party audit was conducted, and auditors noted there were only 4 points (out of 82) where improvements could be made. Finally, within the audit results, ATC noted the actions performed to correct the exceptions found. |
| 6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management. | X | | | | | ATC's ISCA documentation included a number of IT security policies including those that specifically address systems and data access control. Additionally, ATC's system security plans include measures to regularly review and monitor the effectiveness of its access controls. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 7. The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented. | X | | | | | ATC has a robust disaster recovery (DR) and business continuity plan that is tested and reviewed on a scheduled basis. The plan was last reviewed and updated in July of 2020. Also, in July of 2020, ATC's DR plan was tested, resulting in the successful recovery of ATC's IT systems; however, 3 of 29 applications missed the organization's recovery time objectives. The DR test results identified the corrective measures the organization will enact to shorten the recovery time of the 3 applications. |
| **I D. Compliance/Program Integrity** | | | | | | |
| 1. The MCO has a Compliance Plan to guard against fraud and abuse. | X | | | | | ATC's 2020/2021 Compliance and Ethics Program Description integrates all applicable federal and state laws, regulations, accreditation standards, and contractual obligations into daily operations. The 2020 Employee Handbook outlines the role of every employee to demonstrate compliance with the Fraud, Waste, and Abuse (FWA) Program to prevent, detect, and report suspected or instances of non-compliance. |
| 2. The Compliance Plan and/or policies and procedures address requirements, including: | X | | | | | |
| 2.1 Standards of conduct; | | | | | | The Business Ethics and Code of Conduct conveys the company's expectations that employees conduct business in accordance with the standards and rules of ethical business conduct and to abide by applicable laws. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 2.2 Identification of the Compliance Officer and Program Integrity Coordinator; | | | | | | |
| 2.3 Inclusion of an organization chart identifying names and titles of all key staff; | | | | | | |
| 2.4 Information about the Compliance Committee; | | | | | | |
| 2.5 Compliance training and education; | | | | | | Compliance training programs and written publications, provided upon hire and annually, include information on the Compliance Program; the identification of, and mechanisms to report, FWA; the Code of Conduct, Business Ethics and Conduct policy; HIPAA privacy; the Federal False Claims Act; and other compliance related policies, procedures, standards. |
| 2.6 Lines of communication; | | | | | | Lines of communication are outlined clearly in the Compliance and Ethics Program Description. ATC requires its employees to report to management and/or the Compliance Officer all suspected and confirmed incidents of FWA, illegal acts, inappropriate disclosures, and/or other incidents that contravene applicable law, regulations, or ATC's and Centene's Business Ethics and Conduct policy. |
| 2.7 Enforcement and accessibility; | | | | | | |
| 2.8 Internal monitoring and auditing; | | | | | | ATC's Auditing and Monitoring Plan outlines steps taken by the Compliance Department. Audits are conducted specific to contractual |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | assessments annually, as needed, and in conjunction to grievance and appeals activities. |
| 2.9 Response to offenses and corrective action; | | | | | | |
| 2.10 Data mining, analysis, and reporting; | | | | | | Centene's Special Investigation Unit has a dedicated staff and data system to mine claims data to detect billing irregularities and other fraudulent or abusive billing practices. Auditing and detection mechanisms include periodic claims sampling, claims edits, post-processing review of claims, provider profiling and credentialing, quality control, utilization management procedures, and documentation review to assess appropriate billing practices. |
| 2.11 Exclusion status monitoring. | | | | | | According to Policy CC.COMP.16, Fraud, Waste, and Abuse Plan, ATC conducts monthly searches to identify any exclusions and reinstatements that have taken place since the previous search. ATC confirms the identity and determines the status of any "Provider and/or Subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee" through routine checks of federal databases, including the Social Security Administration's Death Master File, the List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), SC List of Excluded Providers, SC List of Providers Terminated for |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | Cause, and any other databases as the Department or Secretary of Health and Human Services may prescribe. |
| 3. The MCO has an established committee responsible for oversight of the Compliance Program. | X | | | | | ATC's Compliance Committee meets quarterly and is chaired by the Compliance Officer. The 2020 Compliance Committee Matrix identifies the voting members. The committee is composition includes a cross-functional team of individuals from within the organization, the Board of Directors, and other senior leadership as needed who have the authority to implement corrective actions. |
| 4. The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse. | X | | | | | |
| 5. The MCO's policies and procedures define how investigations of all reported incidents are conducted. | X | | | | | Policy CC.COMP.16, Fraud, Waste and Abuse Plan, outlines the role of the Special Investigation Committee (SIC), which makes recommendations for the resolution of issues and risks that may affect the FWA Program. Through coordination with the Special Investigations Unit (SIU) and the Payment Integrity Department, the ATC Compliance Department will conduct investigations of suspected FWA by personnel, providers, subcontractors, or members to the extent necessary to determine if reporting to the SC Medicaid Fraud Control Unit and/or the Office of the Inspector General. |
| 6. The MCO has processes in place for provider payment suspensions and recoupments of | X | | | | | For all cases in which overpayments are identified, ATC will initiate its recoupment |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| overpayments. | | | | | | process and notify the Division of Program Integrity in accordance with all contractual requirements. |
| 7. The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP). | X | | | | | Policy SC.PHAR.06, Medicaid Pharmacy Lock-In Program, was developed to detect, monitor, and prevent the excessive use of the pharmacy benefit for ATC Medicaid members. When cases are determined to reflect inappropriate use, a letter of explanation is sent to members with instructions and appeal rights. |
| **I E. Confidentiality**<br>*42 CFR § 438.224* | | | | | | |
| 1. The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy. | X | | | | | Policy CC.COMP.04, Confidentiality and Release of Protected Health Information, applies to employees, officers, and directors of Centene Corporation, its affiliates, and subsidiary health plans. The 2020 HIPAA-PHI Desk-Field Audit Training document clearly outlines ATC policies, desk and work area audit procedures, and step-by-step violation outcomes. |

## II. PROVIDER SERVICES

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| **II. PROVIDER SERVICES** | | | | | | |
| **II A. Credentialing and Recredentialing**<br>*42 CFR § 438.214, 42 CFR § 457.1233(a)* | | | | | | |
| 1. The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements. | X | | | | | Credentialing and recredentialing processes and requirements are documented in Policy CC.CRED.01, Practitioner Credentialing & Recredentialing. Attachment J of the policy includes South Carolina specific requirements. Requirements and processes for credentialing and recredentialing of organizational providers are addressed in Policy CC.CRED.09, Organizational Assessment and Reassessment.<br><br>Policy CC.CRED.04, Nondiscriminatory Credentialing and Recredentialing, describes processes to prevent and monitor for discriminatory credentialing and recredentialing. ATC does not discriminate against providers who serve high-risk populations and who treat costly conditions. |
| 2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO. | X | | | | | Policy CC.CRED.03, Credentialing Committee, outlines the structure, protocols, and processes used to make credentialing decisions. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | The Credentialing Committee uses a peer-review process to make recommendations regarding credentialing decisions. The committee meets monthly, is chaired by the Chief Medical Director, and is overseen by the Quality Improvement Committee (QIC). Committee membership includes network practitioners with specialties of Surgery, Pediatrics, and Psychiatry. ATC's Chief Medical Director confirmed the Plan is considering recruiting additional network providers to serve on the committee.<br><br>Credentialing Committee minutes reflected thorough review and discussion of providers with adverse items in files, discussion of ongoing monitoring and interventions, discussion of delegation oversight activity, etc. A quorum was confirmed for each of the meetings reviewed and member attendance was satisfactory.<br><br>*Recommendation: Consider adding an adult medicine practitioner, such as a Family Practitioner or Internist, to the Credentialing Committee's membership.* |
| 3. The credentialing process includes all elements required by the contract and by the MCO's internal policies. | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 3.1 Verification of information on the applicant, including: | | | | | | |
| 3.1.1 Current valid license to practice in each state where the practitioner will treat members; | X | | | | | |
| 3.1.2 Valid DEA certificate and/or CDS certificate; | X | | | | | |
| 3.1.3 Professional education and training, or board certification if claimed by the applicant; | X | | | | | |
| 3.1.4 Work history; | X | | | | | |
| 3.1.5 Malpractice claims history; | X | | | | | |
| 3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application; | X | | | | | |
| 3.1.7 Query of the National Practitioner Data Bank (NPDB); | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 3.1.8 Not debarred, suspended, or excluded from Federal procurement activities: Query of System for Award Management (SAM); | X | | | | | |
| 3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline); | X | | | | | |
| 3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List; | X | | | | | |
| 3.1.11 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE); | X | | | | | |
| 3.1.12 Query of Social Security Administration's Death Master File (SSDMF); | X | | | | | |
| 3.1.13 Query of the National Plan and Provider Enumeration System (NPPES); | X | | | | | |
| 3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility; | X | | | | | |
| 3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures; | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days. | X | | | | | |
| 4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies. | X | | | | | |
| 4.1 Recredentialing conducted at least every 36 months; | X | | | | | |
| 4.2 Verification of information on the applicant, including: | | | | | | |
| 4.2.1 Current valid license to practice in each state where the practitioner will treat members; | X | | | | | |
| 4.2.2 Valid DEA certificate and/or CDS certificate; | X | | | | | |
| 4.2.3 Board certification if claimed by the applicant; | X | | | | | |
| 4.2.4 Malpractice claims since the previous credentialing event; | X | | | | | |
| 4.2.5 Practitioner attestation statement; | X | | | | | |
| 4.2.6 Requery the National Practitioner Data Bank (NPDB); | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 4.2.7 Requery of System for Award Management (SAM); | X | | | | | |
| 4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline); | X | | | | | |
| 4.2.9 Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List; | X | | | | | |
| 4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE); | X | | | | | |
| 4.2.11 Query of the Social Security Administration's Death Master File (SSDMF); | X | | | | | |
| 4.2.12 Query of the National Plan and Provider Enumeration System (NPPES); | X | | | | | |
| 4.2.13 In good standing at the hospitals designated by the provider as the primary admitting facility; | X | | | | | |
| 4.2.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures; | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 4.3 Review of practitioner profiling activities. | X | | | | | |
| 5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues. | X | | | | | Policy CC.PRVR.23, Provider Termination Policy, describes processes and requirements for both provider-requested and health plan-initiated provider terminations.<br><br>Policy SC.QI.18, Potential Quality of Care Investigations, states ATC monitors member safety through processes to identify potential and actual quality of care incidents. The policy describes processes for referring cases with severity levels of high or critical (levels 3 and 4) to the Peer Review Committee (PRC) for evaluation, action, and closure.<br><br>Policy CC.QI.19, Peer Review Committee and Process, states PRC recommendations to restrict, suspend, or terminate a provider's network participation are reviewed by the Credentialing Committee and/or the Plan Board of Directors for a final determination. The provider may appeal the restriction, suspension, or termination decision, as stated in Policy CC.CRED.08, Practitioner Appeal Hearing Process. |
| 6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities. | X | | | | | Policy CC.CRED.09, Organizational Assessment and Reassessment, defines processes and requirements for initial and ongoing credentialing |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | of organizational providers.<br><br>CCME's review of initial credentialing and recredentialing organizational files confirmed all required elements were included. |
| 7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds. | X | | | | | Policy CC.CRED.06, Ongoing Monitoring of Sanctions & Complaints, confirms that a provider's exclusion from federal procurement activities results in immediate termination of participation in ATC's network. Credentialing staff review and verify provider sanctions and exclusions monthly. |
| **II B. Adequacy of the Provider Network**<br>*42 CFR § 438.206, 42 CFR § 438.207, 42 CFR § 10(h), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)* | | | | | | |
| 1.The MCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements. | | | | | | |
| 1.1 Members have a primary care physician located within a 30-mile radius of their residence. | X | | | | | Policy CC.PRVR.47, Evaluation of Practitioner Availability, outlines and defines mechanisms to monitor the type, number, and geographic distribution of primary care providers (PCPs) to determine network adequacy and how effectively the network meets membership needs, preferences, and diversity. The policy defines PCP access standards as 1 provider within 30 miles/45 minutes for both urban and rural |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | counties. ATC defines PCPs as family practitioners/general practitioners, internists, and pediatricians.<br><br>At least annually, ATC assesses network PCP availability against the defined standards. Data sources may include but are not limited to network adequacy reports/Geo Access mapping and self-reported member data (from member satisfaction survey results and/or grievances about practitioner availability).<br><br>The Geographic Access maps submitted for review indicate 100% of members have access to a PCP using the defined standard of 1 PCP in 30 miles/45 minutes. |
| 1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty. | X | | | | | Policy CC.PRVR.47, Evaluation of Practitioner Availability, also describes ATC's processes for assessing the type, number, and geographic distribution of high-volume and high-impact specialists in ATC's network. The policy defines access standards for High-Volume and High-Impact specialists as 1 provider within 50 miles/75 minutes for urban and rural counties. A South Carolina addendum to the policy defines access requirements for hospitals as 1 within 50 miles/75 minutes.<br><br>At least annually, ATC assesses network specialist |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | availability against the defined standards using the data sources listed in the standard above. |
| 1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually. | | X | | | | The 2020 Medicaid QI Work Plan indicates Geo Access reports are run semi-annually, and onsite discussion confirmed network reporting is provided to SCDHHS twice yearly.<br><br>The *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2* requires MCOs to have executed contracts with all Status 1 Providers. Additionally, the *SCDHHS Contract, Section 6.3,* requires the MCO to submit its provider network to SCDHHS "in accordance with this contract and as detailed in the Managed Care Policy and Procedure Guide" and to ensure "the submission reflects the CONTRACTOR's entire Provider network."<br><br>However, the Geo Access reports (dated December 21, 2020) submitted with ATC's desk materials did not provide evidence that access was measured for the following Status 1 Provider types: General Surgery and Rehabilitative Behavioral Health. Additional documentation (Geo Access mapping) was provided showing measurement of General Surgery and Rehabilitative Behavioral Health providers, but the date of the mapping was 2/26/21, after completion of the onsite. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | *Quality Improvement Plan: Ensure evaluation of network adequacy includes measuring access for all Status 1 providers. Refer to the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2.* |
| 1.4 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs. | X | | | | | As noted in Policy CC.QI.CLAS.29, Cultural Competency and Linguistic Assistance Policy (C&L), members' cultural, linguistic, and accessibility needs are identified, and a demographic analysis is conducted annually. A cultural competency work plan is developed and updated annually.<br><br>Centene/ATC performs regular quality assurance oversight of contracted providers to ensure compliance with cultural, linguistic, and disability access requirements. This is accomplished through review of policies and procedures, site visits, and monitoring member satisfaction survey results, appeals, and grievances.<br><br>Capabilities related to cultural, linguistic, and disability provider access are documented in the Provider Directory. Providers receive ongoing education about cultural competency and are requested to document cultural, linguistic, and disability access capabilities. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | A review of ATC's website confirmed the following training documents are available:<br>•Cultural Competency Quick Reference Guide<br>•Americans with Disabilities Act (ADA) - Disability Awareness Training Quick Reference Guide |
| 1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand. | X | | | | | |
| 2. The MCO maintains a provider directory that includes all requirements outlined in the contract. | X | | | | | Onsite discussion confirmed ATC does not maintain a print (hard copy) version of the Provider Directory; however, members and other stakeholders may contact Member Services to get a list of providers mailed. The online "Find a Provider" tool allows providers to be located by name, location, or specialty. General results can be filtered by distance, provider type, gender, disability access, and status for accepting new patients.<br><br>The online Find a Provider Tool includes all elements required for the Provider Directory. Onsite discussion confirmed the information in the Find a Provider Tool is updated daily.<br><br>The *SCDHHS Contract, Section 3.13.5.7,* and the *Social Security Act, Section 1932(b) (3) (B),* require the provider directory to include a |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | statement that some providers may choose not to perform certain services based on religious or moral beliefs. This statement was not noted in the online Find a Provider Tool or elsewhere on ATC's website. Onsite discussion confirmed this statement was inadvertently removed.<br><br>*Recommendation: Revise the website to include the required statement that some providers may choose not to perform certain services based on religious or moral beliefs. Ideally, this should be on the landing page for the online Find a Provider tool or incorporated into the display of search results.* |
| 3.Practitioner Accessibility<br>*42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)* | | | | | | |
| 3.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements. | X | | | | | Policy CC.PRVR.48, Evaluation of the Accessibility of Services, defines ATC's processes for monitoring member access to primary care, behavioral health, and specialty care services. The SC Addendum to the policy defines the standards for PCP, specialty care, and behavioral health appointment access, which comply with requirements stated in the *SCDHHS Contract, Section 6.2.2.3*.<br><br>As noted in the 2019 QI Program Evaluation, ATC monitors PCP appointment and after-hours |

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| | | | | | | access, as well as appointment accessibility for specialty and behavioral health providers, annually. Actions are initiated as needed to improve access. Monitoring incorporates data and results from member satisfaction surveys, practitioner office surveys, and member grievances and appeals.<br><br>The 2019 Practitioner Access Analysis document indicates ATC conducted a limited number of appointment availability and after-hours call surveys in 2019 due to staff turnover and organizational changes, but additional surveys would be completed in 2020 on a semi-annual basis. Onsite discussion confirmed the studies were conducted in the latter part of 2020. |
| 3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results. | X | | | | | As part of the annual EQR process for ATC, a provider access study, focusing on PCPs, was conducted. A list of current providers was given to CCME by ATC, from which a population of 2,557 unique PCPs was found. A sample of 184 providers was randomly selected from this population for the Access Study. Attempts were made to contact the 184 providers to ask a series of questions regarding member access to the providers.<br><br>Calls were successfully answered 73% of the time (109 of 149) when omitting calls answered by |

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| | | | | | | personal or general voicemail messaging services. When compared to last year's results of 71%, this year's study had an increase in successful calls at 73% (p=.6454). This increase of 2% was not statistically significant.<br><br>For calls not answered successfully (n=40 calls), 11 (28%) were because there was no answer, 7 (18%) were due to a wrong or disconnected phone number, and 18 (45%) were because the caller was informed that the physician was no longer at that location. For the question "Do you accept Absolute Total Care?" 82 out of 109 (75%) confirmed they do accept ATC. Of the 82 providers that responded to the question regarding accepting new Medicaid patients, 56 of 91 (68%) confirmed they are accepting new Medicaid patients; 33 of those 56 (59%) indicated they do have prescreening requirements. Of the 33 providers with prescreening requirements, 23 (70%) required an application and a medical record review, and 9 (18%) required only an application. One provider (3%) required an insurance card and ID. |
| **II C. Provider Education**<br>*42 CFR § 438.414, 42 CFR § 457.1260* | | | | | | |

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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 1. The MCO formulates and acts within policies and procedures related to initial education of providers. | X | | | | | Policy SC.PRVR.13, Provider Orientations, states all newly-contracted PCPs, specialists, hospitals, and other ancillary providers, unless part of an existing in-network group or facility, receive provider orientation within 30 business days of becoming active with ATC. Core elements of provider orientation are found in Attachment A of the policy and additional orientation topics are listed in Attachment B. |
| 2. Initial provider education includes: | | | | | | |
| 2.1 MCO structure and health care programs; | X | | | | | |
| 2.2 Billing and reimbursement practices; | X | | | | | Claims submission and processing is included as a core element of provider orientation. Also, the Provider Manual gives information on general billing guidelines, electronic and paper claims submission, procedures for filing claim/encounter data, claims payment and adjustments, etc. |
| 2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS; | X | | | | | The Provider Manual includes information about covered and non-covered services. |
| 2.4 Procedure for referral to a specialist; | X | | | | | The Provider Manual informs that referrals are not required for members to see specialists. |
| 2.5 Accessibility standards, including 24/7 access; | X | | | | | The Provider Manual, page 7, includes appointment access standards that are compliant for PCP appointments, but does not clearly define all the access standards for specialists. |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | *Recommendation: Revise the Provider Manual to clearly define appointment access standards for specialists. Refer to the SCDHHS Contract, Section 6.2.3.1.5.* |
| 2.6 Recommended standards of care; | X | | | | | The Provider Manual includes information about Preventive and Clinical Practice Guidelines and Protocols. |
| 2.7 Medical record handling, availability, retention and confidentiality; | X | | | | | |
| 2.8 Provider and member grievance and appeal procedures; | X | | | | | Information about appeals and grievances is included in the Provider Orientation PowerPoint, in the Provider Manual, and on ATC's website. |
| 2.9 Pharmacy policies and procedures necessary for making informed prescription choices; | X | | | | | |
| 2.10 Reassignment of a member to another PCP; | X | | | | | |
| 2.11 Medical record documentation requirements. | X | | | | | The Provider Manual includes information about medical record retention requirements, required documentation, records release and transfer, and medical record audits. Standards for medical record documentation are also available on the ATC website. |
| 3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, | X | | | | | Policy SC.PRVR.14, Provider Visit Schedule/On-going Education, states PCPs receive at least one |

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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| policies and procedures. | | | | | | visit per quarter from their Provider/Network Relations Representative, and specialists receive at least 1 visit biannually. Visits are conducted to ancillary providers, as necessary. Provider educational needs are determined by management of Provider/Network Relations. The health plan holds benefit/direct service provider training sessions in at least four regional locations throughout the state at least once a year via webinar or face-to-face sessions.<br><br>Onsite discussion revealed ATC has adjusted its initial and ongoing provider education practices in response to restrictions from the COVID-19 pandemic. All education sessions are conducted through virtual platforms. ATC also conducted a virtual town hall meeting with providers. Staff reported it was well attended and another is being planned soon. |
| **II D. Primary and Secondary Preventive Health Guidelines**<br>*42 CFR § 438.236, 42 CFR § 457.1233(a)* | | | | | | |
| 1. The MCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated. | X | | | | | ATC follows processes described in Policy SC.QI.08, Clinical & Preventive Practice Guidelines, for adopting and distributing preventive health guidelines (PHGs) to assist practitioners and members in making decisions about appropriate health care. |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | ATC adopts PHGs for pediatric, adolescent, and adult populations that are derived from recognized sources. The guidelines are presented to the Quality Improvement Committee (QIC), allowing board-certified practitioners that would use the guidelines to review and give advice on the guidelines. The adopted guidelines are reviewed at least every two years and updated when there is significant new scientific evidence or when there are changes in national standards. |
| 2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers. | X | | | | | Preventive health guidelines are distributed to practitioners based on specialty and upon request. The Provider Manual includes a list of adopted PHGs and a link to access the guidelines on ATC's website. The guidelines may be distributed during new provider orientation and via newsletters, special mailings, and fax blasts. Providers are informed that they may be audited for compliance with use of the guidelines. |
| 3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics: | | | | | | |
| 3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals; | X | | | | | |
| 3.2 Recommended childhood immunizations; | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 3.3 Pregnancy care; | X | | | | | |
| 3.4 Adult screening recommendations at specified intervals; | X | | | | | |
| 3.5 Elderly screening recommendations at specified intervals; | X | | | | | |
| 3.6 Recommendations specific to member high-risk groups; | X | | | | | |
| 3.7 Behavioral Health Services. | X | | | | | |
| **II E. Clinical Practice Guidelines for Disease, Chronic Illness Management, and Behavioral Health Services**<br>*42 CFR § 438.236, 42 CFR § 457.1233(a)* | | | | | | |
| 1. The MCO develops clinical practice guidelines for disease, chronic illness management, and behavioral health services of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists. | X | | | | | ATC follows processes described in Policy SC.QI.08, Clinical & Preventive Practice Guidelines, for adopting and distributing clinical practice guidelines (CPGs) to assist practitioners and members in making decisions about appropriate health care. ATC's guidelines are relevant to its membership and are derived from recognized sources. Guidelines are presented to the QIC for physician review and adoption, are reviewed at least every two years and updated when there is new scientific evidence or changes in national standards. |

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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 2. The MCO communicates the clinical practice guidelines for disease, chronic illness management, and behavioral health services and the expectation that they will be followed for MCO members to providers. | X | | | | | Clinical practice guidelines are distributed to practitioners based on specialty and upon request. The Provider Manual includes a list of adopted CPGs and a link to access the guidelines on ATC's website. The guidelines may also be distributed during new provider orientation and via newsletters, special mailings, and fax blasts. Providers are informed that they may be audited for compliance with use of the guidelines. |
| **II F. Continuity of Care**<br>*42 CFR § 438.208, 42 CFR § 457.1230(c)* | | | | | | |
| 1. The MCO monitors continuity and coordination of care between the PCPs and other providers. | X | | | | | ATC collects data to assess, identify opportunities, and act on opportunities to improve coordination of medical care. The data focuses on coordination of medical care across settings and/or transitions in care. A summary with qualitative and quantitative analysis of the activity is presented to the QIC or other designated subcommittee and included in the Quality Program Evaluation. These activities are documented in Policy CC.QI.09, Continuity & Coordination of Medical Care,<br><br>As noted in the 2019 QI Program Evaluation, ATC identified four areas for ongoing monitoring and action to improvement of continuity and coordination of medical care:<br>•Number of inpatient discharges with outpatient practitioner follow-up visits within 15 days after |

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| | | | | | | discharge<br>•Total number of emergency department visits with outpatient practitioner follow-up visit within 15 days<br>•Total number of members discharged from an inpatient setting following a live birth that had a postpartum visit with a PCP or OB/GYN within 21-56 days following discharge.<br>•Practitioner satisfaction with the communication between PCPs and specialists.<br><br>After collection of data, an analysis was conducted, and barriers and interventions were identified to improve continuity and coordination of care.<br><br>CCME's review of the 8/25/20 QIC meeting confirmed reporting of the outcomes and actions taken. |
| **II G. Practitioner Medical Records** | | | | | | |
| 1. The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians. | X | | | | | Policy SC.QI.13, Medical Record Review, describes ATC's processes for monitoring network providers to ensure they are compliant with documentation standards and that patient confidentiality is maintained. An annual assessment is conducted of selected PCPs; high volume specialists may also be included. |

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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 2. Standards for acceptable documentation in member medical records are consistent with contract requirements. | X | | | | | |
| 3. Medical Record Audit | | | | | | |
| 3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers. | X | | | | | ATC conducts medical record review from a statistically valid sample of practitioners.<br><br>The benchmark score for medical record audits is 80%. Practitioners who score below the benchmark are notified in writing of the score, of identified deficiencies, and of actions required to correct deficiencies. The written notice includes a copy of the completed audit tool and notification that follow-up will be conducted within 6 months.<br><br>At the time of the follow-up, providers who continue to score below 80% are discussed with the Medical Director and Contracting/Network Management leadership for further action, which could include a medical record review conducted by the Medical Director, referral to the QIC or Peer Review Committee, and termination from the network.<br><br>The Medicaid Medical Record Review 2020 Annual Audit Report reveals ATC identified 1113 practitioners who provided medical care to five |

| STANDARD | SCORE | | | | | COMMENTS |
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| | | | | | | or more members. A sample of 69 practitioners was selected for medical record audit. All practitioners received a total passing score of ≥ 80%; the overall score was 95% and 11 practitioners scored 100%. |
| 4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract. | X | | | | | |

## III. MEMBER SERVICES

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| **III. MEMBER SERVICES** | | | | | | |
| **III A. Member Rights and Responsibilities**<br>*42 CFR § 438.100, 42 CFR § 457.1220* | | | | | | |
| 1. The MCO formulates and implements policies guaranteeing each member's rights and responsibilities and processes for informing members of their rights and responsibilities. | X | | | | | Policy SC.MBRS.25, Member Rights and Responsibilities, describes how ATC ensures members of their rights according to the *SCDHHS Contract, Section 3.16*. Newly enrolled members are informed of their rights in the Member Handbook when they receive the Member Welcome Packet and member rights are available on the website. ATC informs members of their rights annually, either in a newsletter or direct mailer.<br><br>Providers are informed of member rights and responsibilities in a yearly copy of the Provider Manual. Providers are expected to display a copy of member rights and responsibilities in their office. |
| 2. Member rights include, but are not limited to, the right: | X | | | | | Policy SC.MBRS.25, Member Rights and Responsibilities, describes how ATC advises members of their rights and responsibilities and how these rights are protected. The recent policy revision no longer includes the listing of member the rights and responsibilities. Member rights are |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | correctly listed in the Member Handbook, Provider Manual, and on the website according to the *SCDHHS Contract, Section 3.16*. |
| 2.1 To be treated with respect and with due consideration for dignity and privacy; | | | | | | |
| 2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand; | | | | | | |
| 2.3 To participate in decision-making regarding their health care, including the right to refuse treatment; | | | | | | |
| 2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations; | | | | | | |
| 2.5 To be able to request and receive a copy of the member's medical records and request that they be amended or corrected as specified in Federal regulation (*45 CFR Part 164*); | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat the Medicaid MCO Member. | | | | | | |
| **III B. Member MCO Program Education** *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)* | | | | | | |
| 1. Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including: | X | | | | | New members receive a Welcome Packet that includes a Member Handbook, an identification card, a provider directory, member education materials, and member rights.<br><br>Policy SC.ELIG.17, Enrollment, states members will be issued a Welcome Packet and an ID card within 15 days of receiving enrollment data from SCDHHS. The *SCDHHS Contract, Section 3.14.3* requires the plan to provide education by the 14th day after receiving enrollment. The policy does not indicate when ATC receives member enrollment data, making it difficult to determine if benefit information is provided within 14 days as required.<br><br>*Recommendation: Edit Policy SC.ELIG.17, Enrollment to indicate when ATC receives member enrollment data from SCDHHS and to reflect that members receive benefit* |

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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | *information in writing within 14 days according to the SCDHHS Contract, Section 3.14.3.* |
| 1.1 Benefits and services included and excluded in coverage; | | | | | | A comprehensive description of covered and non-covered services is included in the Member Handbook. Additionally, benefit information is available on the website. Policy SC.COMM.06, Member Marketing: Marketing and Educational Materials and Activities, correctly describes information required to include in the Member Handbook, in accordance with the *SCDHHS Contract, Section 3.13.2.5.9.* |
| 1.1.1 Direct access for female members to a women's health specialist in addition to a PCP; | | | | | | |
| 1.1.2 Access to 2nd opinions at no cost, including use of an out-of-network provider if necessary. | | | | | | |
| 1.2 How members may obtain benefits, including family planning services from out-of-network providers; | | | | | | |
| 1.3 Any applicable deductibles, copayments, limits of coverage, and maximum allowable benefits; | | | | | | Copayments and limits of coverage are listed in the Member Handbook and on the website. ATC informs members that copays do not apply for well-child/well-baby visits or vaccines, for children under 19 years old, for members who are pregnant, or for institutionalized members, such as those in a nursing facility. |

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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 1.4 Any requirements for prior approval of medical or behavioral health care and services; | | | | | | Services that require prior authorization are clearly listed throughout the Member Handbook and Provider Manual. Prior approval is not required for family planning services, emergency visits, or behavioral health services. |
| 1.5 Procedures for and restrictions on obtaining out-of-network medical care; | | | | | | |
| 1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services, including post-stabilization services; | | | | | | Urgent, emergent, and post-stabilization care are correctly defined in the Member Handbook. Members are informed that in addition to their PCP, the Nurse Advice Line is available 24 hours a day, seven days a week. The Member Handbook and ATC's website provides clear and specific information instructing members on the appropriate level of care for a routine, urgent, or emergent health care need. |
| 1.7 Policies and procedures for accessing specialty care; | | | | | | |
| 1.8 Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions; | | | | | | The Member Handbook includes information on obtaining prescription medications and durable medical equipment. Members are directed to the website to view the Preferred Drug List and to find participating pharmacies or to contact Member Services to obtain this information. |
| 1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network; | | | | | | ATC will send a letter within 30 days prior to the effective date of a PCP's termination. ATC informs members in the Member Handbook that |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | they will be notified of significant changes to the program no later than 30 calendar days prior to implementation. Updates to the Preferred Drug List (PDL) and the Member Handbook are found on the website. |
| 1.10 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care; | | | | | | The Member Handbook and the website give instructions for managing PCP selections and scheduling appointments. Members can call Member Services for assistance or log into their secured online account. |
| 1.11 Procedures for disenrolling from the MCO; | | | | | | The Member Handbook provides information on the requirements for disenrollment and instructs members to call South Carolina Healthy Connections Choices and speak with an enrollment counselor. Policy SC.ELIG.10, Member Disenrollment, describes ATC's process for handling disenrollment requests. |
| 1.12 Procedures for filing grievances and appeals, including the right to request a Fair Hearing; | | | | | | Information and instructions for filing grievances, appeals, and State Fair Hearings are correctly noted in the Member Handbook. Additionally, information is provided on the website and located in Adverse Benefit Determination and Appeal letters.<br><br>As recommended from the previous EQR, the member website section has been updated from "Complaints and Appeals" to "Grievances and Appeals" to be consistent with the verbiage in the Member Handbook. |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 1.13 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office; | | | | | | A description of the Provider Directory is found in the Member Handbook along with instructions to access the Provider Directory on the website. Members can contact Member Services to obtain information about providers such as education, qualifications, and languages spoken, and to request a Provider Directory. |
| 1.14 Instructions on how to request interpretation and translation services at no cost to the member; | | | | | | |
| 1.15 Member's rights, responsibilities, and protections; | | | | | | |
| 1.16 Description of the Medicaid card and the MCO's Medicaid Managed Care Member ID card, why both are necessary, and how to use them; | | | | | | The Member Handbook has sample pictures of the Absolute Total Care/Healthy Connections ID Card and addresses the importance for members to present it at the time of service. |
| 1.17 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services; | | | | | | ATC maintains a Member Services Call Center and 24-Hour Nurse Line. Additionally, the 24-Hour Nurse Advice Line is staffed with mental health professionals who can address the member's urgent behavioral health needs. The TTY:711 relay is communicated in several member materials and on the website. |
| 1.18 How to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling appointments when necessary; | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 1.19 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services; | | | | | | The Member Handbook includes information and instructions for eligible members under 21 years of age to obtain Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. Additionally, the EPSDT Program Description states ATC conducts written, telephonic, and in-person outreach to inform and remind members of necessary EPSDT services. Preventive health guidelines for age-appropriate checkups and the 2021 Recommended Child and Adolescent Immunization Schedule are available on the website. |
| 1.20 A description of Advance Directives, how to formulate an advance directive, and how to receive assistance with executing an advance directive; | | | | | | |
| 1.21 Information on how to report suspected fraud or abuse; | | | | | | Fraud and abuse are correctly defined in the Member Handbook and the website. Instructions are provided for members to anonymously report fraud and abuse to ATC, SCDHHS, and to South Carolina's Division of Program Integrity. |
| 1.22 Additional information as required by the contract and/or federal regulation; | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 2. Members are notified at least once per year of their right to request a Member Handbook or Provider Directory. | X | | | | | |
| 3. Members are informed in writing of changes in benefits and changes to the provider network. | X | | | | | Policy SC.ELIG.14, Member Notification of Provider Termination, states ATC notifies members in writing within 15 days after a receipt of a provider's termination from the network. Policy Addendum CC.PHAR.10, Preferred Drug List, explains that members are notified of changes to the formulary via newsletter or mail on a quarterly basis. Changes to the PDL that negatively impact members will be posted to the website 30 days before the effective date. |
| 4. Member program education materials are written in a clear and understandable manner and meet contractual requirements. | X | | | | | Policy COMM.15, Request, Preparation, and Approval Process for Marketing and Communication Materials, and Policy SC.COMM.19, Member Materials Readability, describe and outline processes to ensure member program materials are written in a clear and understandable manner and meet contractual requirements.<br><br>Materials are made available in other languages when 5% or more of the resident population of a county is non-English speaking and speaks a specific language. Additionally, materials include tag lines in large print explaining the availability of written translation or oral interpretation services if needed. |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 5. The MCO maintains, and informs members how to access, a toll-free vehicle for 24-hour member access to coverage information from the MCO. | X | | | | | The Member Services Call Center is staffed Monday through Friday from 8 a.m. to 6 p.m. Outside of normal business hours, the Interactive Voice Response system instructs callers to call 911 or go to the nearest emergency room for life-threatening emergencies. Callers are given the option to leave a message to which a response is provided within one business day.<br><br>Free interpreter and translation services are provided to members who have limited English proficiency, hearing, speech, or sight communication barriers as described in the Member Handbook, the website, and Policy SC.MBRS.04, Interpreter Services. ATC addresses staffing, personnel, hours of operation, access and response standards, and monitoring of calls in Policy SC.MBRS.28, Telephone Responsiveness and Call Center Performance, and Policy CC.MBRS.09, Member Service Calls.<br><br>The 2019 QI Program Evaluation reports that call center performance goals were met for Average Speed to Answer and Abandonment Rate for medical and behavioral health. The report did not include rates for busy signals of incoming calls and of the average hold time of three minutes or less, as required by the *SCDHHS Contract, Section 3.18.17.3 and 3.18.17.4.* |

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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | During the onsite teleconference, ATC staff explained they have begun updating and revising reports for call center performance standards to include busy signal calls and the average hold time of three minutes or less. |
| **III C. Member Enrollment and Disenrollment** *42 CFR § 438.56* | | | | | | |
| 1. The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed. | X | | | | | |
| 2. MCO-initiated member disenrollment requests are compliant with contractual requirements. | X | | | | | ATC must submit to SCDHHS detailed written requests for member disenrollment. |
| **III D. Preventive Health and Chronic Disease Management Education** | | | | | | |
| 1. The MCO informs members of available preventive health and disease management services and encourages members to utilize these services. | X | | | | | Members can access the website or Member Handbook for information on preventive health services, available case management programs, and instructions to obtain educational support for medical, behavioral health, and pharmaceutical services. Member newsletters are easily accessible on the website. The newsletters are easy to navigate and contain information on many health topics, covering risk factors and wellness promotion, which varies with each edition. |
| 2. The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits. | X | | | | | ATC ensures EPSDT services for members through the month of their 21st birthday. The EPSDT |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | Program Description includes processes and methods for notification, tracking, and follow-up of the EPSDT program and addressing barriers of low utilization by creating interventions to encourage members to use the services. |
| 3. The MCO provides education to members regarding health risk factors and wellness promotion. | X | | | | | The WholeYou member newsletter provides a variety of information regarding wellness and prevention topics such as cancer screening and prevention, well visits, and diseases. The 2019 Quality Improvement Program Evaluation describes how ATC uses outreach calls to inform members about health risk factors and to encourage healthy behaviors. Onsite discussion revealed ATC conducts and participates in community events with established community partners to provide health and wellness information to members and the public. However, due to COVID restrictions, events were not conducted in-person. |
| 4. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in recommended care. | X | | | | | Policy SSFB.01, Start Smart for Your Baby®: Program Overview, and the Member Handbook inform members about the Maternity Education Program. Additionally, ATC tracks timeliness of prenatal care through HEDIS monitoring of pregnant members.<br><br>Pregnant members are identified through a variety of means such as welcome calls, eligibility files, prenatal risk assessments, self- |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | referrals, health risk assessments, physician referrals, and inter-departmental referrals. |
| **III E. Member Satisfaction Survey** | | | | | | |
| 1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. This assessment includes, but is not limited to: | X | | | | | ATC contracts with SPH Analytics, a certified CAHPS Survey vendor, to conduct the Child and Adult Surveys. Response rates for all three surveys decreased in comparison to the response rates in 2019. The Child CAHPS Survey response rate was 11.8%, which decreased from last year's response rate of 18%. The Adult CAHPS Survey response rate was 12.4%, which is a decrease from the 17% rate in 2019. The Children with Chronic Conditions (CCC) CAHPS Survey response rate was 14%, which is a decrease from last year's rate of 18%. The minimum number of completed surveys is less than the National Committee for Quality Assurance (NCQA) target of 411 surveys for all three populations: Adult, Child, and Child CCC. The response rates are also below the NCQA target rate of 40%.<br><br>*Recommendation: Continue working with SPH Analytics to increase response rates and identify methods to improve responses. Social media posts, text reminders (if possible), and reminders during call center interactions are encouraged to be continued.* |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 1.1 Statistically sound methodology, including probability sampling to ensure it is representative of the total membership; | X | | | | | |
| 1.2 The availability and accessibility of health care practitioners and services; | X | | | | | |
| 1.3 The quality of health care received from MCO providers; | X | | | | | |
| 1.4 The scope of benefits and services; | X | | | | | |
| 1.5 Claim processing procedures; | X | | | | | |
| 1.6 Adverse MCO claim decisions. | X | | | | | |
| 2. The MCO analyzes data obtained from the member satisfaction survey to identify quality issues. | X | | | | | SPH analytics summarizes and details all results from Child, Child CCC, and Adult surveys. |
| 3. The MCO implements significant measures to address quality issues identified through the member satisfaction survey. | X | | | | | The minutes from the August 2020 QIC meeting and the 2020-2021 CAHPS Action Worksheet Workbook document give evidence of analysis, discussion, and initiatives to address problematic areas of member satisfaction. |
| 4. The MCO reports the results of the member satisfaction survey to providers. | X | | | | | The 2020 CAHPS Survey results were reported to providers as noted in the Medicaid-Provider-QI Description 2020-508R. |
| 5. The MCO reports results of the member satisfaction survey and the impact of measures taken to address identified quality issues to the Quality Improvement Committee. | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| **III F. Grievances**<br>*42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260* | | | | | | |
| 1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to: | X | | | | | Policy SC.MM.11, Member Grievances, and the UM Program Description describe and outline ATC's grievance processes. ATC accepts grievances by phone, in person, and in writing by mail, fax, email. The Grievance and Appeals Coordinator logs and tracks all grievances, oral or written, into the grievance database.<br><br>Grievance information is provided in the Member Handbook, Provider Manual, and on the website. |
| 1.1 The definition of a grievance and who may file a grievance; | X | | | | | Policy SC.MM.11, Member Grievances, the Member Handbook, Provider Manual, and member website correctly document the definition of a grievance and a description of who can file a grievance. They appropriately indicated that providers and other authorized representatives must have a member's written consent to file a grievance on their behalf. |
| 1.2 Procedures for filing and handling a grievance; | X | | | | | Requirements for filing a grievance are documented in Policy SC.MM.11, Member Grievances, in the Member Handbook, in the Provider Manual, and on ATC's. ATC provides instructions, including mailing address and phone numbers, for grievances to be filed either orally or in writing and will acknowledge the grievance in writing within five business days. |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | The Member Handbook and Provider Manual indicate clinically urgent grievances are reviewed and determined by a Medical Director. As recommended during the previous EQR, the documents no longer reflect that members can request clinically urgent grievances. |
| 1.3 Timeliness guidelines for resolution of a grievance; | X | | | | | Timeliness guidelines for grievance resolution are correctly documented in Policy SC.MM.11, Member Grievances, the Member Handbook, and the Provider Manual. Grievances are resolved within 90 calendar days of receipt. |
| 1.4 Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee; | X | | | | | |
| 1.5 Maintenance and retention of a grievance log and grievance records for the period specified in the contract. | X | | | | | |
| 2. The MCO applies grievance policies and procedures as formulated. | X | | | | | Grievance files reflect timely acknowledgement, resolution, and notification. Grievance resolution notices contain appropriate language, include all contractually-required components, and directly address member concerns. Grievance staff conducted appropriate follow-ups with other departments when monitoring the grievance status. |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee. | X | | | | | Policy SC.MM.11, Member Grievances, explains all member grievances are reviewed by the Quality Improvement Department to identify trends and opportunities for improvement. ATC tracks and monitors member grievance data quarterly. Results and analysis are presented and discussed during QIC meetings and reflected in committee minutes. In 2019, ATC exceeded the established goal of < 5 grievances/1000 members with a rate of 1.04 as noted in the 2019 Quality Assessment and Performance Improvement (QAPI) Program Evaluation. |
| 4. Grievances are managed in accordance with the MCO confidentiality policies and procedures. | X | | | | | |

## IV. QUALITY IMPROVEMENT

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| **IV. QUALITY IMPROVEMENT** | | | | | | |
| **IV A. The Quality Improvement (QI) Program** *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)* | | | | | | |
| 1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members. | X | | | | | ATC provided the Absolute Total Care 2020 Quality Assessment and Performance Improvement Program Description Medicaid and Marketplace for review.<br><br>Per the QI Program Description, ATC's primary goal is to ensure all members have access to the highest quality of health care services that are also responsive to their health needs and able to improve their health outcomes. Other goals include understanding member cultures and languages, improving the continuity and coordination of medical and behavioral healthcare, and improving overall member and provider satisfaction. |
| 2. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems. | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 3. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s). | X | | | | | The Work Plan is developed annually and facilitates improvement activities for the year. ATC provided the 3rd quarter 2019 and 3rd quarter 2020 Work Plans. All requirements for the work plan were met. Identified issues noted in the 2019 work plans were appropriately addressed in the 2020 Work Plan. Some of those issues included: low number of quality of care referrals, low member attendance at the Member Advisory Council, and provider dissatisfaction. Interventions to address these issues were discussed in the Quality Improvement Committee meetings and tracked on the work plan. |
| **IV B. Quality Improvement Committee** | | | | | | |
| 1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities. | X | | | | | The Quality Improvement Committee (QIC) is the decision-making body ultimately responsible for the implementation, coordination, and oversight of the QI Program. Each internal department participates and contributes to the program and works collaboratively on QI activities. |
| 2. The composition of the QI Committee reflects the membership required by the contract. | X | | | | | The QIC membership includes ATC senior management staff, clinical staff, and network practitioners. A quorum must be present to conduct the meeting. A minimum of three voting members, including a senior executive, one ATC staff, and one external practitioner, must be present for a quorum. The senior executive will be the determining vote in the case of a tie vote. |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | Last year, CCME recommended that ATC recruit additional voting members for this committee due to some members not meeting ATC's attendance requirements. To address this recommendation, ATC decided to remove the attendance requirement while ensuring that each department was represented at each meeting. As noted above, a quorum must be met to conduct the meetings; therefore, ATC felt removing the attendance requirement would not jeopardize having enough voting members present. |
| 3. The QI Committee meets at regular quarterly intervals. | X | | | | | |
| 4. Minutes are maintained that document proceedings of the QI Committee. | X | | | | | All committee activities are documented in meeting minutes that are recorded using an approved minute format. |
| **IV C. Performance Measures** *42 CFR §438.330 (c) and §457.1240 (b)* | | | | | | |
| 1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures". | X | | | | | ATC uses Inovalon, a certified software organization, for calculation of HEDIS rates. The comparison from the 2019 rates to the 2020 rates revealed a strong increase (>10%) in several rates, including Statin Therapy Adherence for Patients with Cardiovascular Disease, Comprehensive Diabetes Care - Blood Pressure Control, Statin Adherence for Patients with Diabetes, Diabetes Monitoring for People with Diabetes and Schizophrenia, Cardiovascular Monitoring for People with Schizophrenia, and Postpartum Care. There were no measures with a substantial decline. |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| **IV D. Quality Improvement Projects**<br>*42 CFR §438.330 (d) and §457.1240 (b)* | | | | | | |
| 1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population. | X | | | | | ATC submitted three projects for validation: Postpartum Care, Provider Satisfaction, and Hospital Readmissions. |
| 2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects". | X | | | | | The PIPs validated received a score within the High Confidence Range and met the validation requirements of *42 CFR §438.330 (d)* and *§457.1240 (b)*.<br><br>Last year, it was noted the rate for the Provider Satisfaction PIP decreased from baseline. ATC indicated the provider satisfaction workgroup met and interventions were discussed. Those included additional staff training, the implementation of the Interpreta application that allows network providers to receive real time care gap reports, and hosting regional provider meetings. To help improve Provider Satisfaction, CCME recommended that ATC continue those interventions. For this EQR, CCME was unable to assess the effectiveness of those interventions. The provider satisfaction survey was delayed, and the results were not available for this review. Staff did indicate that preliminary results showed some improvements.<br><br>The Postpartum Care and a new Readmissions PIP were validated during this EQR. The Postpartum Care PIP did show an improvement in the rate although it was still below the benchmark rate. The Readmissions PIP had |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | baseline data only; therefore, improvement was not evaluated.<br><br>Details of the validation of the performance measures and performance improvement projects can be found in *CCME EQR Validation Worksheets, Attachment 3*. |
| **IV E. Provider Participation in Quality Improvement Activities** | | | | | | |
| 1. The MCO requires its providers to actively participate in QI activities. | X | | | | | ATC will systematically profile the quality of care delivered by high-volume PCPs to improve compliance with practice guidelines and clinical performance indicators. The profiling system is developed with ATC network physicians and providers to ensure the process has value to physicians, providers, members, and ATC. ATC's QIC may work with network providers to build useful, understandable, and relevant analyses and reporting tools to improve care and compliance with practice guidelines and performance outcomes. This collaborative effort helps to establish the foundation for physician and provider acceptance of results leading to continuous quality improvement activities that yield performance improvements.<br><br>Profiles will include a multidimensional assessment of a PCP's performance using clinical and administrative indicators of care that are accurate, measurable, and relevant to the target population. Additional assessment, at ATC's discretion, may include such |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | elements as availability of extended office hours, member complaint rates, and compliance with medical record standards. |
| 2. Providers receive interpretation of their QI performance data and feedback regarding QI activities. | X | | | | | ATC profiles the quality of care delivered by high-volume PCPs to improve compliance with practice guidelines and clinical performance indicators.<br><br>ATC indicated that due to COVID-19 and NCQA guidance to rotate rates, if necessary, during the HEDIS 2020 (MY2019) hybrid project, ATC did not have audited rates to send to providers in the provider report cards, so report cards were not sent in CY 2020. |
| **IV F. Annual Evaluation of the Quality Improvement Program**<br>*42 CFR §438.330 (e)(2) and §457.1240 (b)* | | | | | | |
| 1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually. | X | | | | | Annually, ATC evaluates the overall effectiveness of the QI Program and reports this evaluation to the Board of Directors and the Quality Improvement Committee.<br><br>The QI Program Evaluation addressed all aspects of the QI Program. |
| 2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors. | X | | | | | |

## V. UTILIZATION MANAGEMENT

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| **V. Utilization Management** | | | | | | |
| **V A. The Utilization Management (UM) Program** | | | | | | |
| 1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to: | X | | | | | The Utilization Management Program Description outlines the program structure and defines the goals, scope, and staff roles for physical health, behavioral health, and pharmaceutical. The Cenpatico Behavioral Health Utilization Management Program Description and Policy SC.PHAR.09, Pharmacy Program, describes the respective behavioral health and pharmacy programs. Several policies describe UM processes and requirements such as SC.UM.05, Timeliness of UM Decisions and Notifications, and Policy CC.UM.02.01, Medical Necessity Review. |
| 1.1 structure of the program and methodology used to evaluate the medical necessity; | X | | | | | |
| 1.2 lines of responsibility and accountability; | X | | | | | |
| 1.3 guidelines / standards to be used in making utilization management decisions; | X | | | | | |
| 1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification; | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 1.5 consideration of new technology; | X | | | | | |
| 1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services; | X | | | | | |
| 1.7 the mechanism to provide for a preferred provider program. | X | | | | | ATC staff explained the Preferred Provider Program includes one provider. ATC did not make criteria changes to the program due to various COVID-related restrictions and adjustments in 2020 and will reassess for improvement opportunities in 2021. |
| 2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee. | X | | | | | The role of the ATC's Chief Medical Director is described in the 2020 UM Program Description. Responsibilities include, but are not limited to, supervising medical necessity decisions, conducting Level II medical necessity reviews, chairing committees, and overseeing the Pharmacy Management Program. The Behavioral Health Chief Medical Officer has coordination and oversight of the behavioral health UM Program. Responsibilities include, but are not limited to, monitoring compliance activities, participate in Level II medical necessity reviews, and reporting behavioral health UM activities to the Quality Improvement Committee. |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions. | X | | | | | The UM Program is reviewed, evaluated, and updated annually with results and recommendations presented to the Utilization Management Committee (UMC) for review and approval. The UMC is a subcommittee of the Quality Improvement Committee and provides meeting minutes and reports on UM activities.<br><br>The QIC includes ATC's Medical Directors, executive leadership and UM and QI staff, and Network Physicians, who are all voting members. The 2020 UM Program Description and the 2019 UM Program Evaluation were approved by the QIC on May 26, 2020. Committee responsibilities include, but are not limited to, reviewing and approving clinical policies, monitoring utilization trends, and evaluating provider and member satisfaction with the UM Program. |
| **V B. Medical Necessity Determinations**<br>*42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228* | | | | | | |
| 1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations. | X | | | | | Utilization Management standards and criteria are documented in Policy CC.UM.02, Clinical Decision Criteria and Application, and the UM Program Description. InterQual Criteria, ATC clinical policies, and evidenced-based criteria are utilized to determine medical necessity. Individual member circumstances and the local delivery system are considered when determining medical necessity. |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | Behavioral health reviewers utilize InterQual Criteria for specific behavioral health services, American Society of Addiction Medicine criteria for substance use services, and state-specific medical necessity criteria for community based behavioral health services. |
| 2. Utilization management decisions are made using predetermined standards/criteria and all available medical information. | X | | | | | UM approval files reflect review staff follow processes described in Policy CC.UM.02, Clinical Decision Criteria and Application, and Policy SC.UM.55, DRG Concurrent Review, to determine service authorization requests. Use of appropriate criteria, consideration of individual member needs, and requests to obtain additional information when needed were noted. |
| 3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations. | X | | | | | The processes for covering hysterectomies, sterilizations, and abortions are described in Policies SC.UM.45, Sterilization and Hysterectomies, and SC.UM.33, Abortions. The criteria for utilization are communicated in the Member Handbook, the Provider Manual, and on the website. The applicable forms are correctly noted under the provider tab of the website. |
| 4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions. | X | | | | | Policy CC.UM.02, Clinical Decision Criteria and Application, describes how individual circumstances and clinical information pertaining to cases are reviewed and compared to the criteria. A physician reviewer can approve requested services when criteria is not met and clinical evidence supports the decision. |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | Files reflect consideration of individual member needs and requests to obtain additional information when applicable. |
| 5. Utilization management standards/criteria are consistently applied to all members across all reviewers. | X | | | | | |
| 6. Pharmacy Requirements | | | | | | |
| 6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts. | X | | | | | Envolve Pharmacy Solutions is the pharmacy benefit manager for ATC. Pharmacy benefit information is available in Policy CC.PHAR.08, Pharmacy Prior Authorization and Medical Necessity Criteria, Policy SC.PHAR.09, Pharmacy Program, Policy CC.PHAR.10, Preferred Drug List, the Member Handbook, the website, and the Provider Manual. The Preferred Drug List (PDL) provides formulary restrictions and indicates medications requiring prior authorization, limitations, or step therapy. Processes for members to obtain over-the-counter medications are described in the Member Handbook.<br><br>Policy CC.PHAR.10, Preferred Drug List Addendum, is specific to processes in SC. It correctly describes that ATC communicates PDL changes 30 days before the effective date and changes are posted on the website in addition to notifying the impacted member and provider. However, it also describes that PDL changes are communicated annually and that negative PDL changes are only communicated to the member and |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | their provider. This policy is very confusing. ATC staff explained the policy includes both SC specific and corporate processes.<br>The PDL Updates document posted on the website has at least four "effective" dates documented on it. This method of date-stamping is confusing. Additionally, it is difficult to determine when updates truly become effective and if negative changes were posted 30 days prior to implementation, according to requirements in the *SCDHHS Contract, Section 4.2.21.2.1.* For example, the PDL Updates-Q1 2021 documents:<br>•"Effective date 04/01/2021" at the top of the page. CCME notes this date occurs in quarter two.<br>•"*Change will be effective 01/01/2021", and "** Change will be effective 02/01/2021," are at the bottom left of the page and refer to specific medications listed.<br>•"Based on Q1 2021 P&T" is documented on the bottom right of the page.<br><br>*Recommendation: Edit Policy CC.PHAR.10, Preferred Drug List Addendum, to clearly indicate ATC's SC-specific process to communicate negative PDL changes 30 days before the effective date and that changes are posted on the website in addition to notifying the affected member and provider. Edit the Preferred Drug List (PDL) Updates document to clearly indicate the effective date for the drugs listed.* |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity. | X | | | | | Policies SC.PHAR.07, Specialty Pharmacy Program, and SC.PHAR.01, 72-Hour Emergency Supply of Medication, describes ATC's process for approving medication while a prior authorization request is pending. |
| 7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations. | X | | | | | |
| 8. Utilization management standards/criteria are available to providers. | X | | | | | |
| 9. Utilization management decisions are made by appropriately trained reviewers. | X | | | | | ATC ensures UM decisions are conducted by appropriate staff as described in Policy CC.UM.04, Appropriate UM Professionals. Non-licensed staff collect structured clinical data and approve services with clear criteria without interpretation of clinical information. Level 1 reviews are conducted by a licensed nurse. A physician or other appropriately licensed health care professional reviews all authorization requests that cannot be approved during the Level 1 review. Files with adverse benefit determinations reflect decisions are made by appropriate physician specialists. Credentials of reviewers are clearly documented. |
| 10. Initial utilization decisions are made promptly after all necessary information is received. | X | | | | | Service authorization timeframes for approval files are consistent with Policy SC.UM.05, Timeliness of UM Decisions and Notifications, the UM Program Description, and *SCDHHS Contract* requirements. |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| **11. Denials** | | | | | | |
| 11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services. | X | | | | | Denial files reflect attempts to obtain additional clinical information when needed prior to rendering an adverse benefit determination. |
| 11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist. | X | | | | | Adverse benefit determinations reflect decisions are made by the Medical Director or other appropriately licensed health care professional as outlined in Policy SC.UM.07, Adverse Determination (Denial) Notices. |
| 11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal. | X | | | | | Review of denial files revealed adverse benefit determinations were made timely and communicated to the requesting provider and member according to processes described in Policy SC.UM.05, Timeliness of UM Decisions and Notifications. Adverse benefit determination notices were written in language that is clear, without medical jargon, and easily understood by a layperson. Member and provider notices include contractually-required information, such as the action taken by the plan, the member's right to file an appeal with ATC, and to request a State Fair Hearing. An Appeal Form and Authorized Representative Form were enclosed. |
| **V C. Appeals**<br>*42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260* | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including: | X | | | | | Policy SC.MM.13, Member Appeals, and the UM Program Description describe and outline ATC's appeals processes. Additionally, Policy CC.PHAR.08, Pharmacy Prior Authorization and Medical Necessity Criteria, describes specific appeals processes for pharmacy services.<br><br>The Grievance and Appeals Coordinator logs and tracks all appeals, oral or written, in the Appeals and Grievance Database. |
| 1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal; | X | | | | | Definitions of the terms "appeal" and "adverse benefit determination," and a description of who may file an appeal are correctly documented in Policy SC.MM.13, Member Appeals, the Provider Manual, the Member Handbook, and the website. Additionally, the definition of an authorized representative and the requirement that providers and other authorized representatives must have a member's written consent to file an appeal on their behalf is documented across all areas. |
| 1.2 The procedure for filing an appeal; | X | | | | | Requirements for filing an appeal are documented in Policy SC.UM.13, the Member Handbook, the Provider Manual, on ATC's website, and in letter templates, according to the *SCDHHS Contract, Section 9.1.*<br><br>The Absolute Total Care Appeal Form and Authorized Representative Form are enclosed with adverse benefit determination notices and are available on the website. ATC provides the necessary information |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | for members to include when filing a written appeal if the appeals form is not used.<br><br>Members are instructed to submit a signed, written request within 14 calendar days from the date of their oral appeal request, unless an expedited appeal is requested. Members are informed they can provide evidence and review their appeals case file prior to a resolution. |
| 1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case; | X | | | | | ATC ensures decision-makers involved in an appeal were not involved in any previous level of review as described in Policy SC.MM.13, Member Appeals. Additionally, this requirement is communicated in the Member Handbook, Provider Manual, and on the website. |
| 1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay; | X | | | | | Policy SC.MM.13, Member Appeals, describes the expedited appeal process. A physician or other appropriate clinical peer of a same or similar specialty will determine if the request meets criteria for an expedited review. A decision will be made within 72 hours from ATC receiving the request. Review of appeals files reflected appropriate handling of expedited appeal requests. Members were given written notification if the request was downgraded to a standard appeal. |
| 1.5 Timeliness guidelines for resolution of the appeal as specified in the contract; | X | | | | | ATC resolves and provides resolution within 30 calendar days of receipt for standard appeals and within 72 hours of receipt for expedited appeals, as |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | noted in Policy SC.MM.13, Member Appeals. If a request for expedited appeal is denied, the member is notified, and the appeal is processed within the standard 30-day timeframe. |
| 1.6 Written notice of the appeal resolution as required by the contract; | X | | | | | Policy SC.MM.13, Member Appeals, and appeal letter templates addressed all requirements for appeal resolution notices according to the *SCDHHS Contract, Section 9.1.6.2.2 through 9.1.6.3.1.3*. Additionally, State Fair Hearing information is provided in the Member Handbook, the Provider Manual, and on the website. All clearly indicate requests must be submitted in writing.<br><br>The "Notice of Your Right to a State Fair Hearing," enclosed with the Appeal Upheld letter, instructs the reader to "send your request for a hearing, along with a copy of the notice of resolution, within 120 days from the date on the notice of resolution." However, there is no indication on the notice that the appeal upheld letter is the notice of resolution and a layperson may not be familiar with this industry jargon.<br><br>*Recommendation: Consider including a heading or statement on the Appeal Upheld letter template to indicate it is also the Notice of Resolution. This will enable the reader to clearly understand the instructions and reference in the "Notice of Your Right to a State Fair Hearing."* |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 1.7 Other requirements as specified in the contract. | X | | | | | Requirements for continuation of benefits are documented in Policy SC.MM.13, Member Appeals, the Provider Manual, the Member Handbook, and on the website. Appropriate information is provided in prior authorization denial and appeal resolution letters. |
| 2. The MCO applies the appeal policies and procedures as formulated. | X | | | | | The appeals file review reflected reviewers processed standard and expedited appeal requests according to guidelines in Policy SC.MM.13, Member Appeals. Appeal determinations were issued by appropriate reviewers, and acknowledgments and resolutions were completed timely. |
| 3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee. | X | | | | | Policy SC.MM.13, Member Appeals, explains all member appeals are reviewed by the Quality Improvement Department. ATC tracks and monitors member appeals data quarterly. Results and analysis are presented and discussed during QIC meetings and reflected in committee minutes. The 2019 Quality Assessment and Performance Improvement Program Evaluation indicates ATC achieved the established goal of <5.0 appeals per 1000 members with a rate of 2.24 in 2019. |
| 4. Appeals are managed in accordance with the MCO confidentiality policies and procedures. | X | | | | | |
| **V. D Care Management and Coordination** *42 CFR § 208, 42 CFR § 457.1230 (c)* | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 1. The MCO formulates policies and procedures that describe its case management/care coordination programs. | X | | | | | ATC's Care Management and Care Coordination Programs are described in Policy CC.CM.11, Disease Management Programs, and the 2020 Care Management Program Description. The Care Management and Care Coordination Programs focus on prevention, continuity of care, and coordination of services. The Disease Management Program is administered by Envolve People Care and focuses on assisting the member to manage chronic medical conditions. |
| 2. The MCO has processes to identify members who may benefit from case management. | X | | | | | The Case Management Program Description describes methods for identifying and referring eligible members into case management. In addition to such avenues as claims data, laboratory and health risk assessment results, and internal and external referrals, at-risk members are identified through population assessment and analysis. Policy CC.CM.06, Predictive Modeling Methodology, explains ATC uses a predictive modeling and case management analytics tool to identify and stratify members for disease and case management services. |
| 3. The MCO provides care management activities based on the member's risk stratification. | X | | | | | ATC uses a person-centered model that encompasses a multi-disciplinary team approach to case management, as outlined in Policy SC.CM.02, Care Coordination/Care Management Services, and the CM Program Description. Eligible members are assessed for the appropriate level of care management services:<br>•Care Coordination (low risk) - primarily for issues |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | related to Social Determinants of Health.<br>•Care Management (medium risk) - a higher level of service that includes clinical needs.<br>•Complex Care Management (high risk) - a highest level of service that includes complex clinical needs and children and adults with special health care needs.<br><br>The Disease Management Program uses a six-step process to identify and engage with members: Awareness, Identification, Conversation, Assessment, Health Coaching, and Self-Advocacy. |
| 4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members. | X | | | | | ATC adheres to requirements and national standards of the Case Management Society of America (CMSA). CCME identified the CMSA definition of case management is inconsistently documented on page 6 in the CM Program Description and on page 28 of Policy SC.CM.02, Care Coordination/Care Management Services.<br><br>Requirements and processes to assist members in Targeted Care Management with, but not limited to, alcohol and substance abuse, children in foster care, and sensory impairment, are described in the Care Management Program Description and the 2019 Quality Assessment and Performance Improvement Program Evaluation. ATC Case Managers refer identified members to and work collaboratively with the appropriate heath agency until the member is |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | fully transitioned.<br><br>*Recommendation: Ensure the definition Case Management is consistently defined in the CM Program Description and Policy SC.CM.02, Care Coordination/Care Management Services.* |
| 5. Care Transitions activities include all contractually required components. | | | | | | |
| 5.1 The MCO has developed and implemented policies and procedures that address transition of care. | X | | | | | Policies such as SC.UM.41.01, Transition of Care, CC.UM.20, Continuity and Coordination of Services, and the addendum, address transition requirements according to the *SCDHHS Contract, Section 5.6*. ATC conducts appropriate referrals, monitoring, and follow-up to ensure continuity of the member's care. |
| 5.2 The MCO has a designated Transition Coordinator who meets contract requirements. | X | | | | | ATC reported the Transition Coordinator is Lee Jernigan, Director of Case Management. |
| 6. The MCO measures case management performance and member satisfaction, and has processes to improve performance when necessary. | X | | | | | The Care Management Program is evaluated at least annually with results evaluated for effectiveness and reported the UMC and QIC. In 2019, ATC consulted with a vendor to assess the Case Management Program and the identified barriers were "Unable to locate members" and "Providers do not supply Notice of Pregnancy (NOP) to ATC." ATC established interventions to address the barriers and started to |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | see improvement during 2020. Evaluation of the DM Program identified that barriers such as member eligibility, wrong phone numbers, and members refusing to participate contributed to the decline in referrals. Recommendations were made to address the barriers.<br><br>Members actively enrolled in CM for at least 60 days are contacted by telephone and asked to complete a CM satisfaction survey. In 2019, the goal of 90% was met for all survey questions except the response to, "Did your Care Manager consider and include your personal beliefs and preferences during your discussions?" This received an 89% satisfaction score. |
| 7. Care management and coordination activities are conducted as required. | X | | | | | CM files indicate care management activities are conducted as required and Care Managers follow policies to conduct the appropriate level of service. CCME noted that HIPAA verification, identifying care-gaps, and social determinants of health are consistently addressed: Unable to Contact (UTC) letters and education materials are appropriately utilized; CM staff consistently faxed updated care plans to the PCP; and Health Risk Assessment (HRA) were completed timely. |
| **V E. Evaluation of Over/ Underutilization** | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 1. The MCO has mechanisms to detect and document under-utilization and over-utilization of medical services as required by the contract. | X | | | | | |
| 2. The MCO monitors and analyzes utilization data for under and over utilization. | X | | | | | ATC analyzed and monitored utilization data for several services. Recommendations and action plans were offered based on findings from committee minutes and program evaluations. |

## VI. DELEGATION

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| **V I. DELEGATION**<br>*42 CFR § 438.230 and 42 CFR § 457.1233(b)* | | | | | | |
| 1. The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions. | X | | | | | Policy CC.CRED.12, Oversight of Delegated Credentialing, and Policy SC.UM.18, Oversight of Delegated Utilization Management, state that when ATC elects to delegate health plan functions, a document, such as a contract, agreement, letter, or other written record, must be signed by both parties. The signed document defines performance expectations for both ATC and the delegated entity. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | ATC reported delegation agreements with the following credentialing entities:<br>•AnMed Health<br>•AU Medical Center/AU Medical Associates (formerly Medical College of Georgia)<br>•Bons Secours Ambulatory Services – St. Francis LLC (dba AFC Urgent Care)<br>•CVS Caremark Minute Clinic<br>•Health Network Solutions<br>•Lexington Medical Center<br>•Management and Network Services Skilled Nursing Facility<br>•Medical University of South Carolina (MUSC)<br>•Preferred Care of Aiken<br>•Prisma Health (formerly Greenville Health System)<br>•Prisma Palmetto Health/University of South Carolina Medical Group<br>•Regional HealthPlus - Spartanburg<br>•Roper St. Francis Physicians Network<br>•St. Francis Physician Services, Inc (Bon Secours)<br><br>Additional delegation agreements are in place with:<br>•Envolve—24 Hour Nurse Response Line, Disease |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | Management, Pharmacy Benefit Management, and Vision Services<br>•National Imaging Associates (NIA)—Imaging Network |
| 2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions. | X | | | | | Policy CC.CRED.12, Oversight of Delegated Credentialing, and Policy SC.UM.18, Oversight of Delegated Utilization Management, state that prior to signing a delegation agreement, ATC assesses the delegate's capabilities to perform the delegated functions.<br><br>CCME's review of oversight and monitoring documentation confirms annual oversight monitoring is conducted along with quarterly Joint Operating Committee meetings. For one credentialing delegate, a discrepancy in scoring was noted when comparing the Annual Delegation Approval notification letter to the Delegated Credentialing Audit Tool Summary Report. This was discussed during the onsite; ATC responded that this was an oversight and corrected documentation was supplied to CCME for review. |

## VII. STATE-MANDATED SERVICES

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| **V I I. STATE-MANDATED SERVICES**<br>*42 CFR Part 441, Subpart B* | | | | | | |
| 1. The MCO tracks provider compliance with: | | | | | | |
| 1.1 administering required immunizations; | X | | | | | ATC ensures pediatric and adolescent immunization requirements were monitored as described in the EPSDT Program Description. Additionally, information on billing appropriate vaccine codes was listed in the Provider Manual and covered during provider orientation. The immunization schedule is posted on the provider website. The 2019 Quality Assessment and Performance Improvement Program Evaluation details how child and adolescent immunizations are tracked, monitored, and evaluated for improvement opportunities. |
| 1.2 performing EPSDTs/Well Care. | X | | | | | The ESPDT Program Description describes ATC's approach to ensuring all EPSDT services are provided, monitored, and tracked. Providers are expected to provide all EPSDT services according to the current Bright Futures / AAP Periodicity Schedule. PCPs receive monthly reports that identify EPSDT eligible members on their roster that are new to ATC and have not had an EPSDT visit. Provider compliance with rendering EPSDT services is monitored through random medical record reviews as noted.<br>The 2019 Quality Assessment and Performance |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | Improvement Program Evaluation lists ATC's performance on EPSDT/Well-Child visits and describes barriers and improvement opportunities. |
| 2. Core benefits provided by the MCO include all those specified by the contract. | X | | | | | ATC provided all core benefits according to the *SCDHHS Contract*. |
| 3. The MCO addresses deficiencies identified in previous independent external quality reviews. | | | X | | | Geo Access mapping conducted on December 21, 2020 did not include the following Status 1 Provider types: General Surgery and Rehabilitative Behavioral Health. This was an issue identified in the previous EQR.<br><br>*Quality Improvement Plan: Develop and implement a monitoring process to ensure specifications for Geo Access mapping include all Status 1 providers as defined in the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2.* |